

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities			
<input type="checkbox"/> Interim <input checked="" type="checkbox"/> Final			
Date of Report March 12, 2019			
Auditor Information			
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Telephone: 512-490-7971		Date of Facility Visit: July 10-12, 2018	
Agency Information			
Name of Agency Texas Juvenile Justice Department		Governing Authority or Parent Agency (<i>If Applicable</i>) Click or tap here to enter text.	
Physical Address: 11209 Metric Blvd., Bldg. H, Suite A		City, State, Zip: Austin, Texas 78758	
Mailing Address: Click or tap here to enter text.		City, State, Zip: Click or tap here to enter text.	
Telephone: 512-490-7130		Is Agency accredited by any organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Agency mission: Transforming young lives and creating safer communities.			
Agency Website with PREA Information: https://www.tjjd.texas.gov/programs/prea.aspx			
Agency Chief Executive Officer			
Name: Camille Cain		Title: Executive Director	
Email: camille.cain@tjjd.texas.gov		Telephone: 512-490-7004	

Agency-Wide PREA Coordinator				
Name: Carla Bennett-Wells		Title: PREA Coordinator		
Email: Carla.Bennett.Wells@tjjd.texas.gov		Telephone: 254-297-8200		
PREA Coordinator Reports to: Terri Dollar		Number of Compliance Managers who report to the PREA Coordinator 14		
Facility Information				
Name of Facility: Giddings State School				
Physical Address: 2261 James Turman Road, Giddings, Texas 78942				
Mailing Address (if different than above): Click or tap here to enter text.				
Telephone Number: 325-641-4200				
The Facility Is:		<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal	
Facility Type:	<input type="checkbox"/> Detention	<input checked="" type="checkbox"/> Correction	<input type="checkbox"/> Intake	<input type="checkbox"/> Other
Facility Mission: Transforming young lives and creating safer communities.				
Facility Website with PREA Information: https://www.tjjd.texas.gov/programs/prea.aspx				
Is this facility accredited by any other organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Facility Administrator/Superintendent				
Name: Tamu Steptoe		Title: Superintendent		
Email: tamu.steptoe@tjjd.texas.gov		Telephone: 956-289-5500		
Facility PREA Compliance Manager				
Name: Suzie Blansit		Title: PREA Compliance Manager		
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Facility Health Service Administrator				
Name: Amber Laake		Title: Health Services Administrator		
Email: amlaake@utmb.edu		Telephone: 979-542-4500 x4552		

Facility Characteristics		
Designated Facility Capacity: 256		Current Population of Facility: 194
Number of residents admitted to facility during the past 12 months		264
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		247
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		260
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	13.3 – 18.11	
Average length of stay or time under supervision:		244 days 11.4 months
Facility Security Level:		Maximum
Resident Custody Levels:		Low to high
Number of staff currently employed by the facility who may have contact with residents:		350
Number of staff hired by the facility during the past 12 months who may have contact with residents:		70
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		4
Physical Plant		
Number of Buildings: 29		Number of Single Cell Housing Units: 7
Number of Multiple Occupancy Cell Housing Units:		0
Number of Open Bay/Dorm Housing Units:		2
Number of Segregation Cells (Administrative and Disciplinary):		41
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): A video monitoring system with cameras located throughout the interior and exterior of all buildings augments the facility's zero-tolerance efforts. Since the last PREA Audit, no additional cameras or related devices were installed. The current Safe Housing Staffing Plan includes details of the video monitoring for the facility. The gatehouse through which staff members and visitors enter and exit the campus is equipped with a video surveillance system that is monitored by correctional and investigative staff to ensure adherence to the facility schedule and alert others of possible supervision issues. The plan states that video monitoring is performed and documented by supervisory staff at various times each month. Additionally, the plan includes the number of cameras for each dorm, which ranges from 24 to 31. The number of cameras located in each building ranges from 18 – 119. There are 1,300 total cameras for each of the 29 buildings.		

During the onsite portion of the audit, Juvenile Correctional Officers (JCOs) and an Office of the Inspector General staff member were observed monitoring live feed in the gatehouse and through informal interviews, confirmed that their observations are documented on a video review form. Supervisory staff members stated that they are required to conduct monthly random video monitoring and must document their observations and report any concerns. The DVR Quality Assurance Report, which was reviewed on-site, included the staff members' name and title, deficiencies, overall observance, and corrective actions taken for deficiencies. Camera placement was noted during the facility inspection and blind spots were noted and provided to the PREA Compliance Manager.

Video is also used during due process hearings, investigations, allegations of abuse or neglect, and PREA-related allegations, which was confirmed during a review of documentation containing video as evidence considered during a youth's due process hearing.

During the corrective action period, the agency purchased a body-worn camera system for each facility and transitioned the agency-wide use of the cameras one campus at a time. The system contains a suite of operating platforms including a secure server to store video that may be used as evidence for administrative or criminal investigations. The Giddings State School rollout date was October 18, 2018. The facility's staff members were provided training and use of the cameras was implemented at the campus. TJJD policy was amended to contain rules regarding the cameras including check in/out procedures, circumstances allowing the cameras to be deactivated, and oversight duties.

Medical

Type of Medical Facility:	Clinic
Forensic sexual assault medical exams are conducted at:	Seton Smithville Regional Hospital in Smithville, Texas and Dell Children's Medical Center in Austin, Texas

Other

Number of volunteers and individual contractors who may have contact with residents, currently authorized to enter the facility:	139
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	19

Audit Findings

Audit Narrative

Introduction

The Prison Rape Elimination Act (PREA) audit of Giddings State School (Giddings), a secure facility operated by the Texas Juvenile Justice Department (TJJD), is located in Giddings, Texas. The auditor team included three Department of Justice Certified PREA auditors and two non-certified auditors. Nicole Prather was the lead and point of contact throughout the audit; Lisa Hale, Dwight Sadler, and Allen Wallace assisted. The on-site portion of the audit occurred on July 10-11, 2018.

This was the second audit of the facility; the first occurred on October 6-7, 2015 during which time the facility became fully PREA compliant after implementing six corrective actions. In the Summary of Findings section of the 2015 report, the auditor noted:

The standards requiring corrective action were systemic and generally related to a lack of notifications being made to the facility, residents, and the residents' families following PREA related allegations. The numbers provided on the pre-audit questionnaire (PAQ) for criminal cases were inconsistent with the number of criminal cases identified when reviewing Sexual Abuse Review Boards (SARB) documentation.

There were also inconsistencies with the number of SARBs that were held and the number of administrative investigation cases provided.

Youth were not notified of the outcomes of criminal investigations on many occasions, and families and legal guardians were not notified when their child was the victim of an alleged case of sexual abuse.

For the 2018 audit, the auditor team consisted of ombudsmen employed by the Office of the Independent Ombudsman (OIO) for TJJD. A memorandum of understanding (MOU) between the OIO and the TJJD was executed on May 21, 2018 and became effective on June 1, 2018. The MOU stipulates that the Ombudsman will conduct audits of TJJD-operated facilities in accordance with the PREA and requires that TJJD shall reimburse the Ombudsman for travel expenses, including lodging, meals, and mileage, incurred by the Ombudsman in the course of conducting the audits. Once the MOU was effective, the OIO and the TJJD began discussions regarding potential dates for the audits during this audit cycle. Once the dates for each audit were determined, the lead auditor began preliminary discussions. No third-party entity was involved in the audit process.

No barriers hindered the audit process, and the auditor was provided documentation uploaded to a common drive for an initial review. The documents were organized into folders that corresponded to each PREA Standard. Additional phone calls and emails were shared with the facility PREA Compliance Manager, the Interim PREA Compliance Coordinator, and the

Facility Superintendent, which are discussed below in the Pre-Audit phase. During the on-site portion of the audit, the auditor was granted full access to the following:

1. Staff members and youth who were selected to be interviewed prior to the on-site portion of the audit
2. Youth and staff members during informal interviews during the facility inspection
3. All areas in the facility including the 29 buildings, and all closets, offices, individual rooms, restrooms, and storage areas in each building
4. Relevant documents requested prior to the on-site audit, during the audit, following the audit, and during the corrective action period

The audit process was discussed with the Compliance Coordinator, Compliance Manager, and facility Superintendent through emails and phone calls. All understood that the purpose of the audit was to determine compliance with each PREA Standard and that to make determinations, the auditor would need access to supporting documentation, staff and youth, and all areas of the campus. The facility provided each of these, and the auditor determined corrective actions that would enhance current practices, policy and documentation, and staff and youth knowledge and understanding of the PREA Standards. The auditor discussed the corrective actions and interim and final reports timelines with the Compliance Coordinator, Compliance Manager, and the Superintendent.

Pre-Audit

Pre-audit preparation included sending the PREA audit notification to the facility Compliance Manager and verifying the notices were posted at least six weeks prior to the audit and included necessary contact information. The Compliance Manager provided time-stamped photographs of the notices throughout the facility, which confirmed they were posted on brightly colored paper, at least six weeks prior to the audit, and contained the required information. The notices stated that correspondence with the auditor would have been confidential had it been utilized. The auditor received no correspondence from Giddings youth or staff.

The Pre-Audit Questionnaire (PAQ) was initiated once the TJJD PREA audits schedule was confirmed on May 3. On June 13, the upload to a secure agency drive was completed and included the PAQ, TJJD policies, TJJD and facility procedures, and documentation supporting compliance with each standard was complete. The auditor reviewed the PAQ, policies, and other documents including organizational charts, mission statement, protocols, staffing plans, various contracts, and training curricula specific to each standard. Questions and requests for clarification and additional information were listed in the comments section by standard in an issues log, which was emailed to the facility Compliance Manager, Compliance Coordinator, and Superintendent. Responses were typed within the document and additional information was sent beginning on June 13.

An initial phone call was held with the lead auditor, Superintendent, Compliance Manager, and Interim Compliance Coordinator on June 4, 2018. Items discussed included the following:

1. Logistics regarding the size of the auditor team, number of offices needed during interviews, requirement to interview staff members from all shifts, space needed to review documentation on site, and arrival time
2. Audit process and purpose including entrance meeting, triangulation, report requirements, observations and informal interviews during facility inspection
3. Goals and expectations such as becoming fully PREA compliant, collaboration, having access to documents, staff members, campus buildings, and youth
4. Purpose of corrective actions such as enhancing current practices and providing sexual safety to youth and staff
5. Schedule of future communication including the issues log, follow-up phone calls, staff and youth lists, confirmation of on-site audit arrival and estimated departure times
6. Timelines and milestones including issue log, interim report due date, and corrective action period

Following the call, a summary of the items discussed was sent to each participant via email. Attached to the email were the Audit Process Map, Checklist of Policies/Procedures, and the Auditor Handbook.

On June 20, two documents were emailed to the Compliance Manager requesting the completion of the tables containing the required categories of staff members and youth. From these lists, the auditor randomly selected 37 staff members representing each of the specialized designations, two volunteers, and one contractor to be interviewed. Additional details are below in the On-Site section.

The staff fields included staff members with the following designations.

- Superintendent
- Compliance Manager/Coordinator
- Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment
- Medical staff
- Mental health staff
- Non-Medical staff involved in cross-gender strip or visual searches
- Administrative (Human Resources) staff
- Volunteers who have contact with residents
- Contractors who have contact with residents
- Investigative staff
- Staff who perform screening for risk of victimization and abusiveness
- Staff on the sexual abuse incident review team
- Designated staff member charged with monitoring retaliation
- First responders-both security and non-security staff
- Intake Staff

The youth tables were organized into each of the National PREA Resource Center's prescribed targeted populations as follows:

- Youth with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
- Youth who are Limited English Proficient (LEP)
- Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) youth
- Youth who reported sexual abuse
- Youth who reported sexual victimization during risk screening
- Youth in isolation

The Texas Juvenile Justice Department has a young male program located at Giddings for males age 10-14 (or 15 depending on physical size, stature, and maturity), and a separate roster for these youth was generated.

In addition to the facility youth list, the auditor printed a youth population report that included the youth's ethnicity, special education status, limited English proficiency status, age, and dorm assignment. Twenty-eight youth were selected for interviews and represented youth from each targeted category, dorm assignment, age group, treatment needs, and reflected the racial makeup of the campus. Further details are included in the On-Site section below.

A list of selected youth, staff members, volunteers, and a contractor to be interviewed was sent via email to the PREA Compliance Manager two workdays before the on-site portion of the audit to ensure independent responses.

The auditor was granted access to grievances/complaints, incidents, and allegations and hotline calls regarding sexual abuse/harassment for the 12 months preceding the audit. The Office of the Inspector General (OIG), the Administrative Investigation Division (AID), and the facility reported a total of 127 allegations of sexual abuse were received. Allegations may be received through hotline calls to the Incident Reporting Center (IRC), which is monitored by the OIG, written grievances, calling the OIO, or reporting verbally to a staff member, volunteer, or contract employee. Of the 127 sexual abuse/harassment allegations, 63 were assigned to the agency's AID, and 75 were referred for criminal investigation. There were 13 completed AID cases and 27 OIG cases excluding unfounded incidents. The discrepancy in the total cases received and the total assigned is discussed in detail within the standards regarding investigations. During interviews, the AID and OIG investigators reported that there were 26 administrative and 10 criminal cases in progress on the first day of the on-site audit. The Retaliation Monitoring document that includes investigation findings confirmed the number of open cases for OIG. The number of open administrative investigations was based on the AID investigator's interview and could not be confirmed using the retaliation document, as multiple allegations had not yet been assigned.

Prior to the audit, the auditor reviewed the MOU between Giddings and the Bastrop Family Crisis Center and interviewed the Executive Director of the crisis center who stated that the MOU was in place and the following services would be provided:

- SAFE/SANE examinations at the local hospital
- Accompany youth to the examination and during investigation
- Advocacy services through the hotline
- Twenty-four on-call staff
- Counseling services

No external investigators were for administrative investigations, as AID conducts all such investigations.

In previous PREA audits of TJJD facilities, the OIG was reported to be and considered an internal investigative entity. For this audit, the agency and OIG reported that although the OIG and TJJD are administratively associated, the OIG is a separate investigative entity. The Human Resources Code states that the OIG “is established at the department [TJJD] under the direction of the board for the purpose of investigating” crimes committed by TJJD employees and youth, and that “the inspector general shall have all the powers and duties given to peace officers...” The OIG website contains similar information as well as information on reporting to the IRC, quarterly and annual reports, and the special prosecution unit which was established to “assist District and County Attorney offices in the prosecution of criminal investigations conducted” by the OIG.

While no articles relating to Giddings appeared to be PREA-related, an Internet search of the campus yielded the following news articles from newspapers including the San Antonio Express News, Austin American Statesman, Houston Chronicle, Dallas Morning News, and other local papers. The agency, TJJD, is mentioned in multiple additional articles, which are not included in the list below.

- A group of former residents visited the campus to thank staff members for helping them. (September 2015)
- Three youth were injured during a campus riot. (September 2015)
- Staff members knew of a planned fight between rival gangs. (September 2015)
- TJJD policies and staffing shortages were to blame for the Giddings disturbances. (October 2015)
- One of the two teens who had pleaded guilty to capital murder for the murder of one of their parents was released to parole; the other was transferred to adult prison. (May 2016)
- One juvenile reported that being placed in Giddings was hurting him more than helping him. (December 2017)
- Two youth escaped and were apprehended in a nearby county. (April 2018)

The agency website includes the following PREA-related information. Each item is discussed in detail in the relevant standards.

- Policy governing sexual abuse/harassment
- Information on how to report alleged abuse or sexual harassment on behalf of a youth
- Toll-free hotline number
- Aggregated sexual abuse data from TJJD-operated and contracted facilities
- Historical sexual abuse data

The auditor viewed the websites of the two hospitals listed on the PAQ that the facility reported would provide SAFE/SANE services for Giddings youth. One website indicated these services are available. Although the second website did not list this service, on June 28, the auditor interviewed an emergency room supervisor at the medical center. She stated that the hospital employed one SANE nurse who was on call during specific hours. She explained the protocol for conducting this type of examination and provided the general actions to be taken if a Giddings youth needed this service. She also stated that if the SANE nurse was not present nor on call, a referral process was in place to send the youth to an alternate hospital.

The auditor viewed the Texas Department of Family and Protective Services (DFPS) website to verify the mandatory reporting laws. Texas has both civil and criminal laws to protect children from abuse and neglect and states, “If you suspect that a child is being abused or neglected, the law requires that you report it. [Texas Family Code Section 261.101 (a)].” TJJD policy requires that all staff must comply with mandatory child abuse reporting laws in Texas Family Code and meet applicable professional licensure requirements.

The auditor reviewed *Certifications in Texas: A General Overview*, a document from the 31st Annual Juvenile Law Conference held on February 26, 2018. The document contains detailed information regarding certification eligibility for youth over or under age 18, capital murder or murder, due process, appeals, certification hearings, judicial and required findings, and mandatory certifications. The TJJD website also includes certification information as it relates to the agency. Additionally, the Texas Attorney General *2018 Juvenile Justice Handbook* from the 85th legislative session includes a section titled Certification of Juveniles as an Adult, which includes information about the laws governing the transfer of youth to the adult system, offenses that would warrant transfer, jurisdiction of courts, and factors the juvenile court considers prior to certification. These include the sophistication of the juvenile, maturity, previous record, potential danger to the public, and likelihood of rehabilitation.

On-site Audit

Upon arriving to the facility, the auditor met with the facility Compliance Manager, Compliance Coordinator, the facility Manager I, two Dorm Supervisors, and the facility Chaplain to further discuss the on-site portion of the audit and facility inspection. During the inspection the auditor observed the 29 buildings inside the secure fence, which include seven single-cell dorms, two open-bay dorms, and the security unit, which contains 41 segregation cells. Other areas inspected included the offices, interior and exterior mechanical and storage closets, education building,

specialized treatment building, the cafeteria, and the gym. During the inspection, consideration was given to camera placements and potential blind spots, the configuration of dorms, restroom and shower areas, programming activities and educational programs, the level of youth supervision, indicators of any area lacking sufficient monitoring, and PREA notifications and posters. Blind spots were noted by the auditor team and briefly discussed during the exit meeting with the Compliance Manager, Compliance Coordinator, and the facility Manager I. Detailed information was emailed to the Manager, Coordinator, and facility Superintendent.

Grievance forms were available in each dorm, which was confirmed during informal interviews with random youth and the dorm's designated youth grievance clerk. Each stated they had access to locked boxes in which grievances may be placed in the café, education building, and the security unit, which the audit team observed during the facility inspection. Informal interviews with youth and staff confirmed that the boxes remained locked and were checked daily by the youth rights staff member who retrieved and reviewed the grievances.

Processes observed during the on-site portion included medication being dispensed, movement across campus, behavior groups, two youth in the student worker program, school class change, and evening shower routine on two dorms. During each activity, correctional staff members were positioned so that line of sight and overall safety was maintained. On the afternoon of the first day, a disruption occurred: multiple youth climbed to the roofs of several buildings, and for an extended period of time, would not comply with staff instructions come down from the roof. In the evening of that same day, two of the auditor team members returned to the campus at approximately 7:30 pm to observe shower routines on two dorms. Upon arrival, multiple youth assigned to these two dorms were participating in disturbances including running around the pod, standing on tables, yelling, cursing, and breaking personal items bins. One male and one female JCO were present on each pod, and two supervisory staff members arrived to assist. Once youth were secured in the rooms to begin shower routine, the female JCOs were observed sitting with their backs turned and away from the shower area. The male JCOs provided adequate supervision, and the youth had sufficient privacy, as the stalls were out of view of other youth and staff. Based on behavior, one to three youth showered at a time while all others were secured in their cells.

Throughout the inspection, brief informal interviews were conducted with staff members and youth in the security units, education building, the infirmary, and in dorms. The youth-to-staff ratio across campus varied from 1:6 to one 1:12. Compliance with the 1:8 ratio is discussed below in Standard 115.313.

During informal interviews, all youth stated they felt safe and that the level of supervision observed by the auditor team was atypical. Staff stated that there were additional staff members present on the first day of the audit, as it was a "lap day." On these days, the facility schedules additional staff members to provide sufficient coverage during campus-wide activities and/or meetings. Youth in the security unit stated they received daily access to the TJJD hotline and the facility grievance system to report incidents of sexual abuse or any other abuse or concern. The external reporting mechanism is discussed below in Standard 115.321. They said they also received brief daily mental health checks and medical services. The youth telephones were

checked in this and other areas to ensure all were operable and to confirm the number was available for youth to make reports.

Youth and staff members said they were unsure of the frequency or occurrence of unannounced rounds. A review of dorm shift logs indicated all entries and exits to and from the dorm were documented, but unannounced rounds were rarely listed. However, the Unannounced Visit forms for the past 12 months were reviewed on site and indicated these rounds were regularly conducted. Details of the rounds are discussed below in Standard 115.313. The shift logs reviewed during the facility inspection also contained notations of occurrences when opposite-gender staff members announced their presence on the dorm. Youth and staff stated that staff members consistently adhered to this practice, which was corroborated during the inspection when the auditor team observed staff members of the opposite gender announcing themselves as they entered a dorm.

Formal interviews were conducted following the facility inspection on the afternoon of the first day and the morning of the second day. As listed above in the Pre-Audit section, the auditor team interviewed correctional, supervisory, and specialized staff representing different levels of seniority and authority assigned to all three shifts, medical and mental health care staff, agency and facility department heads, contracted services director, and youth from all dorms representing each category of the PREA Resource Center's (PRC's) targeted populations. Youth were randomly selected to ensure sufficient representation of all dorms, dates of arrivals, age range, offense levels and types, stage levels, education levels, and ethnicity. The number of youth from each targeted population was randomly selected to represent the demographic of the facility. Interviews took place in separate spaces in an empty dorm and in offices in the administration building. The SAFE/SANE nurse and director of a local rape crisis center were interviewed by telephone prior to the on-site audit to discuss the agreements in place with the facility to ensure access to services. Two volunteers were also interviewed by telephone to discuss the PREA training they received. The Interim Agency PREA Coordinator, Executive Director, Human Resources Director, Director of Halfway Houses and Contract Facilities, and Manager of Training and Professional Development were interviewed in the TJJD Central Office prior to and following the on-site portion of the audit. The facility Superintendent was interviewed by phone following the audit, as she was in training with the Executive Director at the agency's central office and was not on campus.

The interviewers used the National PREA Resource Center's Interview Protocols for Juvenile Facilities for guidelines and interview questions. Responses to questions regarding staff members' knowledge of PREA policies, reporting responsibilities, first responder and investigative duties, and training were compiled and integral to determining PREA compliance. Youths' responses to questions regarding their knowledge of PREA policies, the education and services they receive, and intake processes were also essential in determining compliance. During interviews, a mental health professional was available to provide services should youth need assistance after an interview, but no youth required or requested this service.

Interview totals were as follows. The facility indicated that no youth who reported a sexual abuse was present during the audit. However, a youth who received notification of the closure of an investigation was interviewed as an additional youth. During his interview, he said that he was involved in consensual sexual contact with a staff member and requested medical services. The interviewer provided this

information to an OIG investigator on site who said the initial investigation was closed but reopened and is currently underway. According to the incident report, a staff member reported the allegation, and an AID case was opened. According to the Sexual Abuse Review Board (SARB) that occurred in October 2017:

- An incident of unauthorized contact with a youth was reported
- The youth denied the allegation
- No retaliation monitoring was assigned because the case was not initially identified as a PREA case
- An OIG case was opened and cleared as not sustained due to insufficient evidence to support a criminal investigation
- The staff member was suspended pending termination in August 2017
- The staff member submitted a resignation effective September 2017.
- An AID investigation was assigned and closed with no violations substantiated
- The SARB committee identified eight actions, five of which were completed
- Actions with no completion date included: review room lighting, staff verbal reminders, and video review of archival footage.

Additional details are included in the relevant standards below. Throughout this report in the interview list, the auditor refers to this youth as a youth who reported a sexual abuse.

Interviewees	Total number at facility	Total Interviewed
Random staff	350	19
Specialized staff	Total not requested	11
Volunteers and contractors	139	3
Random youth	206	23
Disabled Youth	57	5
Youth with limited English proficiency	13	4
Youth who identify as LGBT	1	1
Youth who reported a sexual abuse	1	1
Youth placed in isolation	5	3
Youth who disclosed prior sexual victimization during risk screening	13	3
Young males (age 10-15)	12	2

In addition to completing interviews, the second day of the on-site portion involved reviewing additional documentation for each Standard provided by the Compliance Manager and requested by the auditor. The records of 10 youth corresponding to those who were interviewed were reviewed to determine compliance with intake procedures, safe housing determinations, PREA comprehensive education, and disclosures of prior victimization. Eleven personnel records provided prior to the on-site audit and nine files provided during the on-site audit of random staff members, two staff members who were recently promoted, two volunteers, and one contractor were reviewed to determine compliance with criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings. Personnel files are discussed below in Standard 115.317.

Additional documentation reviewed prior to and during the audit included the following. Each item is discussed below within the relevant standards.

- Organization charts
- Contracts for the confinement and care of youth
- Staffing Plans
- Unannounced Visit forms
- Shift logs
- Safe housing assessments and reassessments
- PREA education materials
- TJJD Youth Handbook
- TJJD Employee Handbook
- Notifications made to youth following an investigation
- Sexual Abuse Incident Review Form
- Facility map with buildings and camera numbers
- Investigative reports or partial reports if criminal
- Training curricula and sign-in sheets
- Medical and mental health case notes
- Youth grievances
- Data collection instrument
- Retaliation Monitoring table and forms
- On-duty supervisor reports
- Nursing protocols
- Campus vulnerability assessments
- DVR quality assurance forms
- Monthly age differential reports

On the afternoon of the second day, the auditor conducted a brief exit meeting to discuss overall PREA compliance, staff and youth knowledge of the PREA, and actions to be taken following the on-site portion with the Compliance Coordinator, Compliance Manager, and Manager I. The

facility Superintendent and Assistant Superintendent were off campus for training at the agency's central office during both days of the on-site portion of the audit.

Post On-Onsite Audit

Following the audit, the auditor team compiled facility inspection, interview, informal interview, and documentation data. Follow-up communications between the auditor and facility leadership requesting additional clarification or documentation were completed. On August 19, 2018, the lead auditor completed the interim PREA Audit Report indicating the compliance determinations for each standard and sent the report via email to the facility Compliance Coordinator, Compliance Manager, and Superintendent. Corrective action was requested for each unmet standard, which initiated the 180-day corrective action period. Communications between the auditor and PREA Coordinator via email, phone calls, and one face-to-face were maintained throughout this period, and one conference call was conducted on November 5, 2018 to specifically discuss standard 115.313. The PREA Coordinator provided periodic updates for corrective actions taken during this time. A summary of these actions is included below on pages 20 – 21, and details are included within the section of each initially unmet standard. Follow-up interviews were conducted at the facility on February 13, 2019 with the facility PREA Compliance Manager, Assistant Superintendent, Director of Nursing, Psychologist II, and three JCOs. The auditor also conducted five formal and seven informal interviews with youth.

Facility Characteristics

Giddings State School is one of five high-restriction facilities operated by the TJJD. The campus was built in 1972, is located in Giddings, Texas, and serves adolescent males between the ages of 13.3 - 18.11 during an average length of stay of 244 days – 11.4 months. Of the 256 cells in the facility, 41 are designated as segregation cells in the security unit, which are used for administrative, self- or disciplinary referrals, temporary assignments, and the Redirect Program for youth who engage in multiple rule violations.

The ethnicity breakdown of the 194 youth as of May 8, 2018, was: 29 white, 59 Hispanic, 94 African American, and two Other. The average daily population for the 12 months preceding the audit was 209. The population on the first day of the site visit was 209.

The total number of staff members as of May 8, 2018 was 350 including JCOs, case managers, mental health professionals, teachers, administrators, supervisory staff members, a family liaison, youth rights specialists, investigators, business administrators, and support staff. The total number of volunteers and contractors was 139.

A secure gatehouse controls entry into and exit from the facility, and the perimeter is contained within a secure fence. The campus comprises 58 acres, which includes areas inside and outside the fence. There are 29 buildings inside the fence including seven single-occupancy dorms, two open-bay dorms, a chapel, vocational and educational buildings, a gatehouse, administrative buildings, a gymnasium, the security unit, and an infirmary. Each area contains extensive video monitoring, which is discussed above on page three. All dorms with the exception of two open-

bay dorms and the security unit house youth in single-occupancy cells with a shared day area. No youth were assigned to the two open-bay units during the audit period.

The facility operates the following programs.

- Capital and Serious Violent Offender Treatment Program for youth who are committed for murder, capital murder, or offenses involving a weapon or deadly force
- Redirect Program
- Pairing Achievement with Success (PAWS - a program in which rescue dogs are housed with youth to be trained and prepared for adoption).
- Aggression Replacement Training
- Sexual Behavior Treatment Program
- Alcohol and Other Drug Treatment
- Young Male Program

Campus processes, including education and medical services, are designed to provide safety including sexual safety, as JCOs are required to maintain line of sight and the staff-to-youth ratios per the campus staffing plan.

Youth receive on-site education services through TJJD, which operates as an independent school district. Youth may earn their diploma or high school equivalency certification, participate in vocational training, or take college classes. Teachers were present in each classroom, JCOs monitored youth inside classrooms and in the hallways, and class change was conducted in a manner that limited the number of youth moving from class to class.

Medical services are provided by the on-site University of Texas Medical Branch (UTMB) clinic. Prescriptions are dispensed during medication pass during which time youth move across campus to the infirmary and receive their medications passed through the infirmary window. JCOs maintained line of sight during this process and required youth to perform a mouth sweep to ensure the medication was taken properly. Sexual assault medical exams are conducted off site at Seton Smithville Regional Hospital in Smithville, Texas or Dell Children's Medical Center in Austin, Texas.

The facility's schedule allots at least one hour per day for recreation, which may occur inside the dorm in the day area, outside, or in the gymnasium. Prior to and during the audit, the facility required a 1:12 ratio, which is also maintained during recreation.

All meals are provided in the cafeteria, which is located near the campus entrance. Youth are required to move to the cafeteria in a straight line with sufficient space between each youth and with their hands behind their backs. JCOs maintain line of sight by walking behind the group of youth. Once inside the cafeteria, youth move through the food line to receive their tray and are seated at tables designed to accommodate four youth. Typically youth sit in pairs across from each other to prevent the sharing of food. JCOs are seated so that they maintain line of sight, and at least two additional staff members are stationed in the cafeteria during meals.

Summary of Audit Findings

*The summary should include the number of Standards exceeded, number of Standards met, and number of Standards not met, **along with a list of each of the Standards in each category.** If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

Auditor Note: *No Standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each Standard.*

The audit findings are based on evidence that is categorized into three groups: documentation, interviews, and observations. To determine compliance, the auditor analyzed evidence in each group, for each provision, for each Standard. The facility policy is assessed according to the PREA Standards and as outlined in the PREA Audit Tool. The auditor assessed supporting documentation, interview responses, and observations according to the Audit Tool, the Audit Checklist, and interview protocols. A summary including the assessment of each these three elements follows each Standard.

The Interim PREA Audit Report findings included 35 standards in compliance, five standards in noncompliance, and one standard that exceeded compliance. Overall, the facility’s policies align with the PREA Standards regarding prevention planning, responsive planning, training and education, screening for risk, reporting, response to allegations, investigations, discipline, medical and mental health care, and data collection and review. Corrective actions are addressed by standard and provision below.

Giddings’ prevention efforts include a zero-tolerance of sexual abuse and harassment evidenced by policy, documentation, and interviews; the education of youth regarding the policy; requirements of contracted entities to adhere to the same zero tolerance; staffing plans intended to protect youth against sexual abuse; and disallowing or limiting cross-gender viewing. Giddings’ supervisory staff members conduct unannounced rounds on all shifts; however, less than one percent of the rounds occurred on Saturdays and none occurred on Sunday. This trend was discussed during the exit meeting and in detail in Standard 115.313 below. A video monitoring system with cameras located throughout the interior and exterior of the buildings augments the zero-tolerance efforts. Interviews with staff and youth indicated they had received training and information regarding the right to be free from sexual abuse and harassment and all could articulate how to make reports. Staff members provided inconsistent responses regarding cross-gender and/or transgender pat down searches.

Evidence of responsive planning includes providing youth with SAFE/SANE services, policy and procedures regarding investigations, and the training of investigators to obtain usable physical evidence. No forensic medical examinations have been necessary, but facility protocol stipulates that youth requiring such examinations would be transported to a local hospital. The

number of administrative and criminal investigations of sexual abuse and harassment allegations reported on the Giddings, AID, and OIG PAQs differ. The number of investigations and notifications at the conclusion of the investigation were also inconsistent. These discrepancies are addressed per standard below. Interviews and training records of investigators, facility staff members, and youth indicate they have received relevant training.

Training and education efforts include the development of training curricula, annual staff training, campus meetings, and dorm meetings addressing PREA-specific topics. Youth PREA education occurs during intake in the Ron Jackson State Juvenile Correctional Center (RJSJCC) Orientation and Assessment (O&A) unit. Interviews with youth indicated PREA education is provided upon their arrival to the unit and continues once they are transferred to their permanent placement. Zero Tolerance posters in Spanish and English are displayed throughout the campus and PREA-related information is included in the youth handbook. During interviews, staff members said they had received PREA training during new-hire and annual trainings. The volunteers and contractor said they received sufficient training regarding PREA policies.

An intake case manager screens each youth for risk of sexual abuse victimization and abusiveness upon the youth's arrival to the agency's O&A unit during the intake interview. The objective screening instrument is used along with psychological assessments to determine housing and room assignments. Subsequent housing decisions are determined by the agency's safe housing reassessments.

Multiple reporting options are present at Giddings. The number for an outside rape crisis center was posted in case managers' offices and is provided to youth once they refuse services provided by Giddings' staff members. This is discussed in detail below in Standard 115.321. Grievance procedures are in place, and youth are provided the tools necessary to complete and submit them. During interviews, staff members and youth could articulate multiple reporting options. Additionally, TJJD's policies align with the PREA Standards regarding the reporting, responses, and immediate actions following a report of sexual abuse. Giddings has a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for specific staff members and the actions each must take. Staff members demonstrated an overall knowledge of first responder duties during interviews.

The TJJD AID conducts in-house administrative investigations and the OIG conducts criminal investigations. One investigator from each division was interviewed and demonstrated compliance with each PREA Standard involving investigations, collection of evidence, notifications, referring for prosecution, and actions taken following an investigation. The administrative investigative reports contained all required information including documentation of youth notifications at the conclusion of the investigation. Additional details of the reports are discussed in the investigation section below.

Final PREA Audit Findings

Number of Standards Exceeded: 1

1. 115.317: Hiring and promotion decisions

Number of Standards Met: 39

1. 115.311: Zero tolerance
2. 115.312: Contracting with other entities
3. 115.315: Limits to cross-gender viewing and searches
4. 115.316: Residents with disabilities and residents who are limited English proficient
5. 115.318: Upgrades to facilities and technology
6. 115.321: Evidence protocol and forensic medical examinations
7. 115.322: Policies for referrals of allegations for investigations
8. 115.331: Employee training
9. 115.332: Volunteer and contractor training
10. 115.333: Resident education
11. 115.334: Specialized training: Investigations
12. 115.335: Specialized training: Medical and mental health care
13. 115.341: Obtaining information from residents
14. 115.342: Placement of residents
15. 115.351: Resident reporting
16. 115.352: Exhaustion of administrative remedies
17. 115.353: Resident access to outside support services
18. 115.354: Third-party reporting
19. 115.361: Staff and agency reporting
20. 115.362: Agency protection duties
21. 115.363: Reporting to other confinement facilities
22. 115.364: Staff first responder duties
23. 115.365: Coordinated response
24. 115.366: Preservation of ability to protect residents from contact with abusers
25. 115.367: Agency protection against retaliation
26. 115.368: Post-allegation protective custody
27. 115.371: Criminal and administrative investigations
28. 115.372: Evidentiary standards for administrative investigations
29. 115.373: Reporting to residents
30. 115.376: Disciplinary sanctions for staff
31. 115.377: Corrective action for contractors and volunteers
32. 115.378: Disciplinary sanctions for residents
33. 115.381: Medical and mental health screenings; history of sexual abuse
34. 115.382: Access to emergency medical and mental health services
35. 115.383: Ongoing medical and mental health care
36. 115.386: Sexual abuse incident review
37. 115.387: Data collection
38. 115.388: Data review for corrective action
39. 115.389: Data storage, publication, and destruction

Number of Standards Not Met: 1

1. 115.313: Supervision and monitoring

Recommendations: 7

1. 115.313: Supervision and monitoring
2. 115.331: Employee training
3. 115.332: Volunteer and contractor training
4. 115.351: Resident reporting
5. 115.363: Reporting to other confinement facilities
6. 115.365: Coordinated response
7. 115.386: Sexual abuse incident review

Compliance for the standards with recommendations was based on practice and interview information, but the auditor recommended implementing the changes to improve current practice and/or revising policy to improve alignment with PREA Standards; however, the implementation of these recommendations has no implication on compliance.

Summary of Corrective Actions Requested

115.312: The agency's MOUs with two contract care facilities exempted those facilities from the required 1:8 ratio.

115.313: For the one year prior to and during the on-site audit, the agency's policy stated, the facility's staffing plan required, and documentation and interview information indicated that the facility maintained a ratio of 1:12 ratio during waking hours.

115.315: Interview responses indicated that additional training was needed regarding 1) exigent circumstances that would warrant a cross-gender search, 2) the difference between a cross-gender search and transgender/intersex search, and 3) circumstances that would warrant a visual search.

115.321: The initial MOU with a rape crisis center included a statement indicating that youth would only be offered these services after he or she refused in-house counseling. The facility's coordinated response stated that the services would be offered once the youth returned to the facility after the exam.

115.353: During the on-site audit, the address and/or telephone number was posted in the case manager's offices but was not readily accessible to youth, and during interviews, youth stated they were unaware of outside services.

Summary of Corrective Actions Taken

Since the on-site audit, the facility has taken corrective actions for all of the standards the auditor determined were noncompliant. After conducting document review and follow-up, on-site

interviews and observations at the facility during the 180-day corrective action period, the auditor determined that Giddings State School demonstrated compliance for four of the five initially unmet standards. A brief description of the actions taken is included in this section, and additional details are included throughout the report in each relevant standard. Additionally, any actions taken as a result of the auditor's recommendations are included throughout the report in the standard section for which a recommendation was made.

115.312: The two MOUs with contract-care facilities were amended and executed to require this ratio; thus, the auditor determined the facility meets the requirements of this standard.

115.313: The PREA Coordinator provided information regarding the steps the agency and facility have taken and plan to take to reach the 1:8 ratio. Based on interviews and documentation, the facility did not achieve and the agency did not require a 1:8 ratio during waking hours during the 180-day corrective action period. As a result, the auditor determined that the facility does not meet the requirements of this standard. The corrective action steps taken thus far are described below in the section addressing this standard.

115.315: During the corrective action period, all facility staff members attended training that addressed: 1) exigent circumstances that would warrant a cross-gender search, 2) the difference between a cross-gender search and transgender/intersex search, and 3) circumstances that would warrant a visual search. Based on follow-up interviews and training documentation, the auditor determined the facility meets the requirements for this standard.

115.321: The PREA Coordinator provided the amended MOU with the local rape crisis center, the facility's revised coordinated response plan, and the agency's revised institutional operations policy. The modified language in these documents aligns with the requirements of this standard. The Coordinator also provided evidence that all staff members received training regarding the changes, and facility staff members stated they received the training during follow-up interviews. Based on these actions, documents, and interviews, the auditor determined the requirements of this standard were met.

115.353: The PREA Coordinator provided documentation that all youth received education regarding the available services of a rape crisis center and a new youth orientation packet that includes the center's pamphlet, which outlines the services offered, phone number, and address. During interviews, youth said that they received this information during dorm meetings, confirmed that the pamphlet was included in the orientation packet they received, and stated the center's contact information is posted in their dorms and accessible. Based on documentation and interviews, the auditor determined the facility meets the requirements for this standard.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA Standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA Standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (a), (b), (d)(1-2)
3. INS 71.01
4. Giddings and TJJD organizational charts

Interviews:

1. Compliance Coordinator
2. Compliance Manager

Observations:

1. Compliance Coordinator and Compliance Manager performing PREA-related duties

(a): The TJJD General Administrative Policy (GAP) along with the Institution Operations Policy (INS) outline TJJD's written policy mandating zero tolerance of and TJJD's response to sexual abuse, sexual harassment, or sexual activity. The policies contain PREA-related definitions, general provisions, prevention planning, responsive planning, training and education, screening for risk, reporting, responses following a report, investigations, disciplinary sanctions, medical and mental health care, incident reviews, and data collection and storage.

(b): The TJJD has a designated agency-wide PREA Compliance Coordinator as well as facility-level PREA Compliance Managers. The TJJD, Monitoring and Inspections Division, and Giddings Organizational Charts evidence the positions of the Interim PREA Compliance Coordinator and facility Compliance Manager within the agency. The agency Compliance Coordinator reports to the Director of Monitoring and Inspections Division. The Giddings chart shows that the facility Compliance Manager reports to the facility Superintendent. The agency

Compliance Coordinator said she has sufficient time and authority to perform her duties and is able to interact with the facility Compliance Managers on a regular basis. The Giddings Compliance Manager said accomplishing her PREA-related duties was difficult at times as she has many additional duties in any given work week. However, she said she could perform her duties and is able to work with the management team to make sure new policies are implemented, monitoring efforts are reviewed, and documentation collected and analyzed.

(c): The TJJD employs an agency Interim PREA Compliance Coordinator and a PREA Compliance Manager at each facility. The TJJD, Monitoring and Inspections Division, and Giddings Organizational Charts indicate the positions of the PREA Compliance Coordinator and facility Compliance Manager within the agency. The agency Compliance Coordinator reports to the Director of Monitoring and Inspections Division. The Giddings chart shows that the facility Compliance Manager reports to the facility Superintendent. The primary responsibility of the Coordinator is to coordinate PREA compliance efforts at each of the TJJD facilities, which includes six secure facilities and eight halfway houses. The Compliance Manager at the facility is responsible for PREA compliance efforts at his or her respective campus. The Giddings' Compliance Manager coordinates all PREA compliance efforts and said she had sufficient time and authority to perform these duties, which include working with facility leadership to ensure new policies, and practices are implemented and deficiencies corrected.

Summary of Findings:

The auditor reviewed the TJJD's PREA Policy and evaluated the document against the requirements of this Standard and the PREA Audit Tool, which stipulate: the policy must a) be written, b) mandate zero tolerance, and c) mandate the designation of agency-wide Compliance Coordinator and facility-level Compliance Managers. The agency's written PREA Policy contains each of these three requirements, which supported compliance with provision (a). The organizational chart includes the Compliance Manager and Compliance Coordinator positions as required by the facility policy and provisions (b) and (c), which supports compliance with these provisions. During interviews, although the Compliance Manager stated performing her PREA-related duties during a 40-hour workweek was sometime difficult, she was able to complete the required tasks outlined in provisions (b) and (c). The Compliance Coordinator stated she has sufficient time and authority to be effective in her roles as provisions (b) and (c) require. Both staff members stated they have dedicated offices, and throughout the audit, they were observed interacting with facility employees and performing duties related to the audit, which further supported the auditor's determination of compliance with provisions (b) and (c). Based on the documents reviewed, interview responses, and observations, the auditor determined the facility satisfied each element in the Audit Tool, demonstrated compliance with all provisions, and thus meets the requirements of this standard.

Corrective Action: None

Standard 115.312: Contracting with other entities for the confinement of residents
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA Standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes
☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA Standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☒ Yes ☐ No
☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. Contracts the agency has entered into for the confinement and care of youth
4. Contract Provider: PREA Continued Compliance Monitoring form
5. Multiple Contract Residential Site Visit Forms

Interviews:

1. TJJD Manager of Youth Services Contracts
2. Director of Halfway Houses and Contract Facilities

Observations:

1. No observations were required, as Giddings is not a contracted facility.

(a): The TJJD's policy requires that "all new or renewed contracts for residential placement of TJJD youth, TJJD includes a clause requiring the contractor to adopt and comply with applicable PREA standards." The TJJD website indicates it contracts with nine entities, and nine contracts for the confinement of youth were provided prior to the audit. Three foster care/group home contracts do not require compliance with the PREA but do stipulate that the service provider "will be required to provide PREA education to staff and youth as well as post TJJD zero tolerance posters in common areas of the facility/foster home." Six contracts contain an article requiring compliance with the Final Rule of the PREA, and each of these contains additional language in an exhibit outlining the program standards regarding youth-to-staff ratios. Of these six, four require "1 direct care staff to 8 youth during waking hours and 1:16 during sleeping hours" and two require "1 direct care staff to 12 youth during waking hours and 1:16 during sleeping hours." These two also state "TJJD has granted the contractor a waiver from the PREA-required ratios that go into effect October 1, 2017." The contracts for the facilities required to comply with the PREA include language stating the contractor will "self-monitor" for compliance as well as acknowledge that "TJJD will conduct announced and unannounced compliance monitoring visits." The contracts also state the contractor is "responsible for paying for a PREA audit every three years."

(b): The TJJD requires all of the contracted facilities to comply with the PREA except the two that are foster care/group home programs and the two that received a waiver from TJJD from the PREA-required 1:8 ratio during waking hours. The TJJD's Director of Halfway Houses and Contract Facilities described her monitoring responsibilities as conducting site visits, observing, reviewing documentation, and interviewing youth. The auditor reviewed PREA Continued Compliance Monitoring forms and Contract Residential Site Visit forms; the forms include notes that intake forms, risk screening, staffing plan, and policy were reviewed during the monitoring visit by the Director of Halfway Houses and Contract Facilities. The site visit forms also include a note stating that PREA posters were observed.

Summary of Findings:

The auditor reviewed the TJJD contract language and evaluated the language against the requirements of this standard and the PREA Audit Tool, which stipulate: a) the contract must require compliance with the PREA Standards and b) the contract must provide for monitoring of the contractor. The contract language for two contracts does not require compliance with all PREA standards and states that these facilities are required to provide a ratio of 1:12 during waking hours, which does not support compliance with provision (a), which requires a ratio of 1:8. However, all contracts require monitoring visits from the contractor, and the monitoring

forms evidenced that monitoring occurred between audits, which support compliance with provision (b). During her interview, the Director of Halfway Houses and Contract Facilities described the monitoring visit procedures, which also support compliance with provision (b). Since the TJJD does not require all contracted facilities to comply with all standards and has granted two facilities a waiver from the PREA-required ratio, the TJJD does not demonstrate compliance with provision (a), and thus, does not meet the requirements of this standard.

Corrective Action:

1. Revise the contract language to reflect that all contracted facilities are required to comply with all PREA standards including the 1:8 staff-to-youth ratio during waking hours.

Corrective Actions Taken since the Interim Audit Report:

The PREA Coordinator provided the auditor two amendments to contracts for secure residential program services for two facilities. The amendments address staff-to-youth ratios and were revised to read “1 direct care staff to 8 youth during waking hours and 1:16 during sleeping hours.” The amendments were signed by the TJJD Executive Director, the service provider, and a TJJD attorney in October 2018. The Facility Administrator at one of these facilities stated that the new contract was executed, which required the facility to maintain ratios per PREA standards. Since the TJJD requires all contracted facilities, including the two that were exempted prior to the corrective action, to comply with all PREA standards, the auditor determined that TJJD demonstrates compliance with each provision, and thus, meets the requirements of this standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☐ Yes ☒ No
- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☐ Yes ☒ No
- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☐ Yes ☒ No
- Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video

monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☐ Yes ☒ No
- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or Standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No
☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☐ Yes ☒ No ☐ NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☐ Yes
☒ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. GAP 380.9955 (d)
4. Staffing plans
5. Time-stamped evidence of unannounced rounds
6. Unannounced visit forms that include the staff member's name, shift, and observation notes
7. Facility ratio reports

Interviews:

1. Facility Superintendent
2. Compliance Manager
3. Compliance Coordinator
4. Staff responsible for conducting unannounced rounds

Observations:

1. Camera placement
2. Video surveillance system
3. Staffing levels during facility inspection

(a): The TJJD policy requires each facility to develop a written staffing plan that considers staffing levels and patterns, video monitoring, and deviations from the plan. The Superintendent must approve the plan for each dorm with consideration given to each element for provision (a) of this standard. The Superintendent and Compliance Manager stated each item in this provision is considered when updating the facility staffing plan. The Superintendent stated that the Compliance Manager updated her about blind spots and that she worked with IRD to adjust camera angles as needed. She said the development process included meeting with the Assistant Superintendent, dorm supervisors, her supervisor, the Compliance Coordinator, and medical staff to develop the staffing plan. She stated that to ensure the facility complied with the plan, unannounced rounds were conducted, observations made, schedules adjusted, and incidents reviewed. The current and previous three annual staffing plans include supervisory signatures indicating approval. The TJJD Director of State Programs and Facilities provided a memo in March 2017 describing the development process, which includes three phases and the actions taken during each phase. These include conference calls with facility superintendents, in-person meetings, and occasional consultation with finance leadership and the Director of PREA Compliance and a review by the Senior Director of Finance, the Compliance and Accountability Officer, and the Director of State Programs and Facilities. Per the safe housing plans, the Compliance Manager reported reviewing safe housing rosters once per week to compare to each youth's stage, assigned room, and risk level to monitor for discrepancies. This was supported with signed and dated safe housing dorm census reviews.

Additional Safe Housing Staffing Plans from the previous three years illustrate the facility's annual review of the plans.

(b): The facility ratio reports and interviews with the Compliance Manager and Superintendent indicated the facility did not deviate from the staffing plan in the past 12 months. TJJD policy states that deviations are only permitted during limited and exigent circumstances and that any deviation and the reason for the deviation must be documented. Since the facility did not deviate from their staffing plan, no documentation of deviations was available.

(c): TJJD policy requires that the facility maintain a staff-to-youth ratio of 1:12 during youth waking hours and 1:16 during youth sleeping hours. Only security staff members are included in the ratio. Giddings considers any staff member who has completed Juvenile Correctional Officer training a security staff member. The April 2018 Safe Housing Plan indicates that each dorm requires a ratio of no less than 1:12, which does not demonstrate compliance with this provision. A memo dated March 2017 from the Director of State Programs and Facilities states that the memo served "as the catalyst prompting a new approach, the methodology used, and the ultimate results that identify the number of staff needed at institutions to provide a 1:8 supervision ratio in compliance with the Prison Rape Elimination Act (PREA), as well as the number of staff needed to maintain the agency's current 1:12 ratio." Additionally, the Director of State Programs and Facilities wrote that the State Programs and Facilities Division has worked with the executive team, finance, and facility administrators to develop a three-phase plan to implement the 1:8 ratio for fiscal year 2018 with legislative approval. The facility reported on the PAQ, staff members reported during interviews, and the safe housing plan indicates that Giddings maintains a ratio of 1:12, which does not support compliance with this provision. During the exit meeting, the Compliance Coordinator stated that Giddings would develop and implement a plan to reach the 1:8 ratio during the corrective action period. The Superintendent stated that she was working with central office staff members to develop a plan to enable the facility to place two staff members on each dorm and meet the ratio requirement. She also stated a recent staffing change was the addition of assigning a staff member in the control rooms in the dorms with this area.

(d): Four consecutive-year safe housing plans were reviewed, and each includes staffing plan procedures, provisions, revisions to the campus schedules and current population, procedures regarding room and dorm assignments, reassessing for safe housing, PREA supervision requirements, and facility floor plans and camera totals. TJJD policy requires the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. The memo provided by the Director of State Programs and Facilities describes the development process, which includes three phases and the actions taken during each phase. According to the document, the Senior Director of Finance, the Compliance and Accountability Officer, and the Director of State Programs and Facilities review the plan. The Superintendent, Director of Secure Facility Operations, Senior Director of State Programs and Facilities, and the Compliance Coordinator approved the plan, which is indicated by their signatures. The

Compliance Coordinator stated she was consulted regarding any assessments of or adjustments to the staffing plan and that staffing plan assessments occurred at least annually. During the exit meeting, she also stated that Giddings would develop and implement a plan to reach the 1:8 ratio during the corrective action period.

(e): TJJD policy requires managerial staff members to conduct and document unannounced rounds at least twice per month on each shift. Policy also prohibits staff members from notifying other staff members that unannounced rounds are occurring. Supervisory staff responsible for conducting unannounced rounds said they are required to do so at varied times, must document them on the Unannounced Visit form, and are discouraged from alerting other staff that unannounced visits are occurring. The auditor reviewed time-stamped photographs and Unannounced Visit forms that include the staff member's name, shift, and observation notes prior to the audit and the unannounced visits schedule on site. The document indicates that rounds occurred at least twice per month for nine of the 12 months in calendar year 2017 and for all months except one during calendar year 2018 thus far. Percentages of rounds occurring on each day of the week conducted in 2017 and 2018 through July are as follows:

Sunday	0%
Monday	12%
Tuesday	29%
Wednesday	21%
Thursday	35%
Friday	.03%
Saturday	.01%

Summary of Findings:

The auditor reviewed TJJD Policy, staffing plans and reviews, and unannounced rounds forms. These documents were assessed against the requirements of this standard and the PREA Audit Tool, which require: a) the development and implementation of a staffing plan that provides adequate staffing levels and the determination of the need for video monitoring; b) compliance with the plan and documentation of deviations; c) maintaining PREA-required staffing ratios; d) at least annual assessments of the staffing plan, staffing patterns, video monitoring systems, and available resources; and e) conducting and documenting unannounced rounds.

The facility staffing plan and development process include all elements of provision (a). However, as indicated above in the yes/no questions section, the auditor used the PREA-required 1:8 ratio to determine whether the facility provided "adequate levels of staffing." The facility's review includes staff members' signatures confirming their presence and documented safety measures taken as a result of the review, thus supporting compliance with provisions (a)

and (d). Evidence supporting compliance with provisions (a) and (b) was demonstrated during interviews, as the Superintendent and Compliance Manager described the staffing plan review process, communicated knowledge of the items in provision (a), and reported the facility had not deviated from the plan. Although the staffing plan is based on a 1:12 ratio, compliance with provision (b) was evidenced, as the facility did not deviate from their plan and agency policy. To demonstrate compliance with provision (c), the facility must maintain staff ratios of a minimum of 1:8 during waking hours and 1:16 during sleeping hours except during limited or exigent circumstances, and such circumstances shall be documented. The PAQ indicated the facility deviated from the 1:8 ratio “every day” in the past 12 months. Additionally, the facility did not provide documentation of each such instance, and thus does not demonstrate compliance with this provision. The facility demonstrated compliance with provision (e) as completed unannounced rounds documentation evidence the practice of conducting these rounds. Based on the documents reviewed, interview responses, and observations, the auditor determined the facility satisfies all but one element in the Audit Tool and demonstrates compliance with all but one provision. Since the TJJD policy does not require and the facility did not maintain a staff-to-youth ratio of 1:8 as required by provision (c), the auditor determined the facility does not meet the requirements of this standard, and a corrective action was initiated.

Corrective Action:

1. Revise policy and update the campus staffing plan to require a 1:8 ratio during waking hours. Provide evidence that the 1:8 ratio is maintained daily except in limited and exigent circumstances. Provide documentation of each instance the facility deviated from the 1:8 ratio.

Corrective Actions Taken since the Interim Audit Report:

The PREA Coordinator provided information via email and during follow-up phone calls regarding the policy in place that dictates the agency’s ratio requirements, the steps the agency and facility have taken to reach the 1:8 ratio, and future actions the facility will take to reach this ratio.

The TJJD response indicated that the facility follows TJJD GAP policy, which addresses the statutory requirements of the Texas Human Resources Code (HRC), which requires TJJD to maintain a ratio of one staff performing direct supervision for every 12 youth.

The auditor agrees that Giddings complies with the HRC and TJJD policy; however, compliance with this PREA standard requires a ratio of 1:8 during waking hours.

The TJJD provided information included in the PRC FAQ, which outlines the staff members who may count towards the 1:8 ratio. TJJD also provided information regarding the training requirements that mandates “that all staff members receive hazardous duty pay are trained in a similar capacity as JCO staff which allows TJJD to utilize additional staff members in addition to JCO to meet the required PREA ratios. Staff members meeting this criteria include teachers, case managers, mental health professionals, volunteer coordinators, family liaisons, recreation staff, administrators and etc. As PREA allows for other staff members aside from juvenile correctional officers to be included in the 1:8 PREA ratio, moving forward, TJJD facilities will update

staffing plans and other relative documentation to include all eligible staff members, in addition to JCO staff, that are utilized to supervise youth but as GAP 380.9955 was written to address TJJD's statutorily mandated JCO requirements, it will not be revised at this time."

The auditor noted that the agency would not revise policy within the 180-day corrective action period. To make a determination of compliance without revisions made to policy, the auditor requested a revised staffing plan that included the additional eligible staff members referenced in the response above, any other relevant documentation that would demonstrate changes were put into place, and documentation that would demonstrate the institutionalization of the changes. While TJJD communicated their intent to utilize additional individuals aside from JCOs to supplement supervision of youth, documentation demonstrating that these changes had been put into place was not provided; therefore, the auditor could not determine compliance.

TJJD outlined the efforts the agency has and/or is taking to achieve compliance with this standard. These included:

1. The Texas Juvenile Justice Department is currently making great strides towards improving juvenile justice reforms and fulfilling its mission of creating safer communities at each facility. A strategic plan has been implemented to achieve compliance and increase facility safety incorporating the following steps:
 - a) Increasing JCO Staffing at all facilities
 - b) Stabilizing dorm assignments to help decrease attrition
 - c) Redefining Fixed Posts
 - d) Maximizing Contract care placement for youth in order to decrease facility populations
 - e) Utilizing hazardous duty staff to supplement the 1:8 ratio when actively supervising youth during the capacity of their assigned job duties.
 - f) Designating the Youth Safety Officer/ PREA Compliance Manager to routinely assess campus coverage for compliance with the 1:8 ratio.
 - g) Documenting and retaining records of all deviations from the 1:8 ratio
2. Any deviations to a facility's staffing plan will be appropriately documented.

None of the steps above have been fully executed as of the end of the corrective action period and a timeline for the completion of each step was not provided.

Additionally, during the follow-up, on-site interviews, staff members reported maintaining a 1:12 ratio during waking hours as required by agency policy and the Giddings staffing plan. The PAQ and initial document review indicated that deviations from the staffing plan had not been documented. During initial and follow-up interviews, staff members stated that no deviations from the required ratio were documented, as none had occurred. Although the PAQ noted that the facility deviated from the 1:8 ratio every day during the previous 12 months, staff members reported that deviations from the 1:8 ratio were not documented

because the ratio was not yet required. Since interview responses and documentation discussed above indicate the facility has not yet implemented the 1:8 ratio, and deviations from this ratio were not documented, the auditor determined that the facility does not demonstrate compliance with this standard.

Recommendations:

1. During calendar year 2017 through June 2018, three unannounced rounds were conducted on Fridays, one was conducted on Saturday, and none were conducted on Sundays. To decrease predictability and cover each day of the week, conduct unannounced rounds on Friday and during the weekend.
2. Compliance for this standard was supported by the description of the development process provided by the TJJD Director of State Programs and Facilities and through interviews with the PREA Compliance Coordinator and Superintendent. Although the description of the staffing plan development process includes each of the required elements, the auditor recommends clearly recording discussions or exchanges of information regarding the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. Records could include meeting minutes, sign-in sheets, emails, or documentation of phone calls regarding the discussions or participation in the development process.

Actions Taken in Response to the Auditor's Recommendations:

During follow-up interviews, the facility Compliance Manager stated and provided evidence that the unannounced round schedule was revised to include weekend shifts. The schedule includes the staff member responsible for conducting the rounds, the shift, and the day of the week.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No
- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. GAP 380.9709 (g)
4. TJJD Professional Development Lesson Plan including a narrative with Key Points
5. Shift and search logs
6. Training curricula
7. Staff training logs

Interviews:

1. Compliance Manager
2. Facility Superintendent
3. Correctional staff
4. Random youth

Observations:

1. Individual rooms
2. Showers and bathrooms in all dorms
3. Shower routine on two dorms

(a): TJJD policy and the training curriculum page outline the use of cross-gender pat-down and strip searches by the opposite gender. Both state that two trained staff must be present and the staff members conducting the search must be of the same gender as the youth, except in exigent circumstances. Policy allows body cavity searches only with probable cause that the youth has contraband and with the authorization of the facility administrator and must be conducted off-site by medical personnel.

(b): TJJD policy prohibits cross-gender pat-down searches except in exigent circumstances and defines such circumstance but does not provide specific examples. Policy also requires that staff members honor a youth's preference to be searched by a male or female staff member if the youth identifies as transgender or intersex. During interviews, all youth reported being pat searched by a same-gender staff member, and none reported being searched by a cross-gender staff member. One youth who identified as LGBT was present during the audit. The youth stated that he informed the facility that he preferred to be searched by a female but "to make it easy, [he] lets males." He also stated, "a lot of females refuse" to perform the search and conduct a visual search instead.

Staff members provided inconsistent responses and understanding of cross-gender pat searches and when/if such a search would be warranted. Two staff members who were intermediate or higher level could articulate exigent circumstances during which a cross-gender search might occur. They also understood that these searches must be documented. One education staff member said school personnel were not trained on how to conduct pat searches. All other staff said under no circumstance would they conduct a cross-gender pat search and that no exigent circumstance would warrant this type of search. They said they would conduct a visual search if no same-gender staff was available. Several staff members described policy and procedures regarding transgender searches when asked about cross-gender searches. The interviewers provided additional information and support to the interviewee, but many staff members did not understand the difference between a cross-gender search and a transgender search. Two staff members expressed confusion regarding transgender pat searches for a transgender female who had been assigned to the facility. They said the practice had included 1) conducting the search according to the youth's preference, 2) conducting visual searches only, and 3) having a staff member according to the youth's preference search the "top" and a "same sex search the bottom."

Although no transgender youth was present at the facility, one transgender female was assigned to Giddings in the past 12 months. Documents related to this youth were reviewed and included general youth data, offense history, initial safe housing assessment, cognitive functioning, re-entry planning, and placement decision. The initial assessment stated that the youth admitted gender confusion, sometimes preferred to be called by a female name, and preferred to be housed with males. An email thread contained discussions about how to conduct pat searches on this youth. The emails contained references to policy and indicated there appeared to be some confusion about how the searches were conducted; however, the emails indicated the facility staff members made their pat search decisions in good faith and based on the youth's initial preferred gender.

(c): TJJD policy requires that all room and pat-down searches, including any performed by cross-gender staff, are documented. Search logs were provided prior to and during the on-site audit and included the dorm, youths' names, items found, reason for the search, and the staff member who conducted the search. No cross-gender pat-down searches were noted.

(d): TJJD policy prohibits cross-gender supervision during shower and restroom routine and when youth change clothes except in exigent circumstances or when such viewing is incidental to routine room checks. Staff members of the opposite gender are required to announce their presence when entering dorms, and signs are posted reminding them to do so. Staff members and

youth reported the practice of announcing opposite-gender staff members is consistently followed, and the auditor team observed this procedure. A sample of Daily Dormitory Shift Logs included notations of occurrences when opposite-gender staff members announced their presence on the dorm.

During interviews, staff and youth reported that youth were able to undress, shower, and use the bathroom out of view of all staff members including those of the opposite gender and all other youth. The auditors observed a shower routine on two dorms containing two pods each. All youth were secured in their rooms and brought out one to three youth at a time for their six-minute showers. A male JCO maintained proximity to the shower area except when conducting room checks on the hallway nearest the showers. The female JCO sat away from the shower with her back facing that area and conducted room checks on the hallway farthest from the area. The control room cameras were checked to ensure the clothes changing area, shower, and bathroom allowed youth privacy. During informal interviews, youth and staff stated the procedure the auditors observed was the typical process.

(e): TJJD policy prohibits searching or examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. During the audit, one youth who identified as LGBT stated that he had not been searched to determine his gender because staff knew he "had male parts." Staff members communicated an understanding of the policy during interviews.

(f): TJJD policy requires that room and pat-down searches are conducted in a professional manner, and staff must not make jokes, conversation, or comments while conducting searches. Policy also requires that staff conducting a pat-down search must be of the same gender as the youth being searched, except in exigent circumstances. A training module titled *Search Procedures* includes the procedures for pat searches including cross-gender, transgender, and intersex pat searches. The Manager of Training and Professional Development at the TJJD Central Office said that the training is provided during on-the-job training and during a town hall meeting when the information was first disseminated during the corrective action period of the RJSJCC PREA audit in March 2017. Giddings' staff members responded inconsistently when asked about policy specific to cross-gender pat-down searches, whether they received training related to these searches, whether Giddings allows such searches in exigent circumstances, and what constitutes an exigent circumstance.

Summary of Findings:

The auditor reviewed policy and training curricula regarding strip, body cavity, and cross-gender searches and compared these documents against the details of this standard and the PREA Audit Tool, which: a) prohibit cross-gender strip and body cavity searches; b) prohibit cross-gender pat searches except during an exigent circumstance; c) require documentation and justification of cross-gender visual body cavity searches and cross-gender pat searches; d) require policy and procedures that ensure residents' privacy while showering, changing clothes, and performing other bodily functions; requires staff members of the opposite gender to announce their presence; e) prohibit examining a transgender or intersex youth to determine genital status; and f) require training regarding searches.

Evidence of compliance includes policy and training materials that align with provisions (a) – (f). However, compliance with provision (b) was not demonstrated as staff members’ inconsistent responses during interviews indicated additional training was needed. The facility demonstrated compliance with provision (c) as search logs showed only allowable searches were performed. The auditor determined compliance with provision (d) because: 1) the auditor observed opposite-gender staff members following policy by announcing their presence when entering dorms, and providing youth privacy during a shower routine, 2) staff and youth reported this was the expected practice, and 3) bathrooms, showers, and rooms were observed to provide privacy to youth when changing clothes, showering, and performing bodily functions. The auditor determined the facility meets the requirements of provisions (a), (c), (d), and (e) after reviewing policy, making observations, and interviewing staff members and youth. The auditor determined the facility does not meet the requirements of provisions (b) and (f), as staff members responded inconsistently when asked about cross-gender pat searches and exigent circumstances. Also, the email thread regarding the transgender youth indicated additional training is needed. Corrective action was initiated for these two provisions.

Corrective Action:

1. Provide additional training to address staff members’ misunderstanding of 1) exigent circumstances that would warrant a cross-gender search, 2) the difference between a cross-gender search and transgender/intersex search, and 3) circumstances that would warrant a visual search. Follow-up interviews with staff members will also be used to determine compliance.

Corrective Actions Taken since the Interim Audit Report:

The PREA Coordinator reported:

- Facility Town Hall meetings were held on November 1, 2018.
- Staff received training from a TJJD training specialist regarding PREA-related definitions and topics as described above in the corrective action request.
- The training was based on the most recent TJJD curriculum.
- The training specialist dispelled all rumors regarding visual searches.
- Pat-down and cross-gender search procedures were addressed.

The auditor reviewed the training acknowledgment forms including the staff member’s name, signature, job title, and facility confirmed that staff received the training in November to confirm the training occurred and staff members attended. The auditor also reviewed a handout from the training that included PREA definitions of exigent circumstances, gender nonconforming, intersex, transgender, cross-gender searches, and a Sexual Orientation Gender Inedited and Expression table.

During follow-up interviews with staff members, they stated they received training and were able to articulate 1) exigent circumstances that would warrant a cross-gender search, 2) the difference between a cross-gender search and transgender/intersex search, and 3) circumstances that would warrant a visual search.

Through document review and interviews, the auditor confirmed 1) the facility provided additional training, and 2) staff members understood their pat search responsibilities, stated they received training on how to conduct cross-gender pat searches, could describe and give examples of exigent circumstances, and confirmed they were prohibited from searching or examining a transgender or intersex youth for the purpose of determining the youth's genital status. After the corrective actions were taken, the auditor determined that facility meets the requirements of this standard.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)

- ☐ **Does Not Meet Standard** *(Requires Corrective Action)*

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. Giddings list of staff translators
4. PREA script in English and Spanish
5. Contract sign language interpreting service
6. PREA Orientation Training and Acknowledgement Form

Interviews:

1. Youth with intellectual disability
2. Youth with limited English proficiency
3. TJJD Executive Director
4. Staff members who provide PREA training to youth

Observations:

1. Interactions between staff members and residents

(a): The TJJD has taken steps to ensure youth with disabilities have equal opportunity to participate in and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. Effective communication with these youth includes utilizing a contract with San Marcos Interpreting Service for the Deaf and the use of special education teachers for youth needing speech therapy and for youth who are visually impaired. The contract with the interpreting service states the language interpreting services are provided to Giddings State School and the Austin metropolitan, Travis County area.

During interviews, intake staff said that orientation involves a staff member reading the PREA Orientation Script to youth and the youth watching the PREA Orientation video on the same day the youth is placed at Giddings.

According to Word's built-in text leveling tool, the provided script has a Flesch-Kincaid reading grade level of 13.3 meaning youth with college level reading skills would be able to read and/or

understand the document. Additionally, excerpts from the youth handbook regarding PREA have an overall reading grade level of approximately 8.4. A modified table with a reading level of grade 4.9 was provided and is included as an insert in the handbook. The table outlines sexual abuse truths and untruths adapted from the report, *Hope for Healing: Information for Survivors of Sexual Assault in Detention*.

Posters throughout the campus in English and Spanish provide youth with information about how to report abuse, neglect, or exploitation. Ten youth including those who have limited English proficiency, low IQ, and low reading ability, reported understanding the information they received regarding Giddings' zero tolerance policy and reporting options.

(b): TJJD has taken steps to ensure youth who are limited English proficient have equal opportunity to participate and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. Bilingual staff members are utilized as English/Spanish translators and English and Spanish versions of the PREA Orientation Script, PREA posters, and youth handbooks are available. Ten youth including those who have limited English proficiency, low IQ, and low reading ability, reported understanding the information they received regarding Giddings' zero tolerance policy and reporting options.

(c): TJJD policy prohibits the use of youth to interpret, read, or otherwise assist except in limited circumstances. Giddings reported no occurrences of the use of youth interpreters in the last 12 months. Staff members stated they would not use youth interpreters except in exigent circumstances.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require: a) youth with disabilities have equal opportunity to participate or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse and harassment; b) youth who are limited English proficient have meaningful access to these efforts; and c) resident interpreters will not be used except in limited circumstances.

The auditor determined TJJD policy addresses each of these requirements, which support compliance with provisions (a) and (c). Evidence supporting compliance with provisions (a) and (b) include a list of staff members who could provide translation services and the MOU with a language line and an interpreting service that would provide language assistance to youth with limited English proficiency or who are deaf or hard of hearing. Interviews with staff members provided evidence of compliance with provisions (a) and (c), as they described the processes for providing PREA-related information to youth and reported that youth interpreters would not be used to assist youth in making a report of sexual abuse or harassment. Although Word's built-in text leveling tool leveled the PREA-related material provided to youth at grade levels ranging from 4.9 – 8.4, the auditor made a final determination of compliance with provision (a) based on youths' understanding and ability to articulate the education they received. Youth signatures acknowledging their receipt of PREA education provided additional evidence of compliance with provision (a). Youth interviews also supported evidence of compliance with provision (c) as

they reported youth readers were not used to relay information or to assist in making reports. When considering whether staff members effectively communicated with youth, the auditor observed staff members interacting with youth and determined that general communication with youth was age and reading level appropriate.

Corrective Action: None

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?
☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?
☒ Yes ☐ No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. PRS 02.07

4. GAP 385.8181(d)
5. PRS 02.08 (f)(1)(A)(ii)
6. Personnel files
7. Human resources electronic records
8. Snapshot provided by the TJJD Human Resources Administrator showing hire date, initial and annual criminal background checks, and fingerprint dates

Interviews:

1. Facility human resources administrative staff
2. Agency central office human resources administrative staff

Observations: No observations relative to this Standard were required

(a): TJJD policy prohibits hiring or promoting anyone who may have contact with youth and using the services of any contractor who may have contact with youth if the person 1) has engaged in sexual abuse in a prison, lockup, community confinement facility, juvenile facility, or other institution or 2) has been convicted or civilly or administratively adjudicated of engaging or attempting to engage in such activities. Eleven personnel records provided prior to the on-site audit and nine files provided during the on-site audit of random staff members, two staff members who were recently promoted, two volunteers, and one contractor were reviewed to determine compliance with criminal background checks, disclosure of PREA Standards violations, reference checks, Child Abuse Registry checks, and acknowledgment forms from PREA annual and refresher trainings.

(b): TJJD policy requires that for any person who may have contact with youth, TJJD consider any incidents of sexual harassment in determining whether to hire, promote, or contract for services. Interviews with Human Resources administrative staff members demonstrated compliance with this practice. They said the sex offender registry is consulted annually and since all staff members are fingerprinted, any arrest would trigger notification to the Human Resources Administrator.

(c): TJJD policy requires that before hiring a new employee who may have contact with youth, TJJD conducts 1) a criminal background check, 2) child abuse registry check, and 3) contact of prior institutional employers to determine any substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Forms placed in each personnel file include Background Reference Check, Internal Background Review, Disclosure of PREA Employment Standards Violation, and Child Abuse Registry Check Consent Form. The facility reports that in the past 12 months, criminal background checks were conducted for 105 persons hired who may have contact with youth. Interviews with Human Resources administrative staff verified the practice of conducting such checks for all employees.

(d): TJJD policy requires that before enlisting the services of a contractor who may have contact with youth, TJJD performs criminal background checks and consults the Child Abuse Registry. The background check of one contractor indicates a criminal background check was conducted

prior to the contractor having contact with youth. The facility reports that in the past 12 months, criminal background checks were conducted for four contracts for services for all staff covered in the contract who may have contact with youth.

(e): TJJD conducts annual criminal background checks, which exceeds the requirement of conducting checks at least every five years. The Human Resources Administrator stated annual checks are conducted for staff, volunteers, and contractors. The initial and annual criminal background check histories of Giddings employees and additional personnel file review also support compliance with this Standard.

(f): TJJD policy requires that applicants and employees who may have contact with youth have an affirmative duty to disclose misconduct described in Subsection (a). The Disclosure of PREA Employment Standards Violation form placed in all personnel files supports compliance with this provision. The agency and facility Human Resources Administrators stated staff must disclose any misconduct.

(g): TJJD policy requires that material omissions regarding such misconduct or the provision of materially false information is grounds for termination.

(h): TJJD policy requires that unless prohibited by law, TJJD provides information on substantiated allegations of sexual abuse or harassment involving a former employee upon receiving a request from an institutional employer for whom the former employee has applied to work. Interviews with Human Resources Administrators support compliance with this practice.

Summary of Findings:

The auditor assessed TJJD policy and the employment application process against the elements of this standard and the PREA Audit Tool, which require: a) the agency shall not hire or promote anyone who has engaged, been convicted of, or has been adjudicated to have engaged in sexual misconduct; and b) the agency consider incidents of sexual harassment when hiring or promoting employees or contracting services.

Based on the comparison, the auditor determined that TJJD policy aligns with the requirements of provisions (a) – (f). The auditor reviewed personnel files and determined necessary background and criminal history checks were conducted more frequently than provision (e) requires. Additional evidence relied upon for provision (f) included verifying that all employee files contained an annual Disclosure of PREA Employment Standards Violation that was attached to the employee's annual performance evaluation. During interviews, the human resources administrators articulated the agency's and facility's hiring and promotion processes as described in policy and this standard. Two files of employees who had recently been promoted indicated that a background check was conducted prior to the promotion. The auditor determined

TJJD and Giddings exceed the requirements of this standard based on the interview responses, documentation review, and evidence of annual background checks.

Corrective Action: None

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.) ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be

included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Facility map with buildings and camera numbers

Interviews:

1. Superintendent
2. Executive Director

Observations:

1. Camera placement

(a): This subsection is not applicable, as the facility has not made substantial expansions or modifications.

(b): Since the last PREA Audit, no additional video cameras were installed. However, the Superintendent and Executive Director reported that the safety, including sexual safety, of youth is considered when installing the cameras.

Summary of Findings:

Because the agency did not acquire a new facility and Giddings had not made substantial expansions or modifications of the existing facility, the auditor determined compliance with provision (a). When considering compliance with provision (b), the auditor: 1) reviewed the facility staffing plan, 2) noted camera placement during the facility inspection, and 3) reviewed the responses of the Superintendent and Executive Director. The staffing plan references the video monitoring system indicating this topic was considered. The interview responses confirmed that when cameras are added, the intent is to provide additional safety. The cameras and live feed observed during the onsite audit confirmed the camera placement provided additional coverage. For these reasons, the auditor determined compliance with provision (b), and thus the facility meets the requirements of this standard.

Corrective Action: None

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No
- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (f)
3. INS 71.01
4. Mental health care training documentation
5. MOU with the Bastrop Family Crisis Center
6. Website for Dell Children's Medical Center in Austin, Texas

Interviews:

1. Staff members
2. The emergency room supervisor at Seton Smithville Regional Hospital in Smithville, Texas
3. Compliance Manager
4. Compliance Coordinator
5. Executive Director of the Bastrop Family Crisis Center
6. Random youth

Observations: No observations relative to this standard were required.

(a): The TJJD Office of the Inspector General (OIG) is responsible for conducting all criminal investigations. The Administrative Investigations Division (AID) conducts all other sexual abuse and harassment allegations involving staff members. The OIG investigators generally work Monday through Friday but are on call during non-work hours. When sexual abuse allegations are made, the facility procedures are outlined in policy and the Giddings State School's Written Plan of their Coordinated Response to Allegations of Sexual Abuse. During interviews, all but three staff members understood the evidence collection process. All but two could articulate their

first responder duties and stated they would separate the youth, protect the scene, and notify supervisory staff and the IRC. All but two understood that OIG and AID were responsible for conducting investigations.

(b): TJJD policy requires that the agency follow a uniform evidence protocol when responding to allegations sexual abuse and states that the protocol must be developmentally appropriate for youth. Both agency (AID) and outside (OIG) investigators follow a uniform evidence protocol, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition, April 2013.*

(c): TJJD policy requires that when appropriate, TJJD transports youth who experience sexual abuse to a hospital that can provide a medical examination by a SANE or SAFE. If such exams were necessary, depending on the age of the youth, Giddings would transport youth to Dell Children's Medical Center in Austin, Texas or Seton Smithville Regional Hospital in Smithville, Texas. The auditor viewed the websites of the two hospitals; one indicated these services were available, and although the second website did not list this service, the auditor interviewed an emergency room supervisor at that hospital. She stated that the hospital employs one SANE nurse who was on call during specific hours. She explained the protocol for conducting this type of examination and provided the general actions to be taken if a Giddings youth needed this service. She also stated that if the SANE nurse was not present nor on call, a referral process was in place to send the youth to an alternate hospital. TJJD policy requires that medical examinations by a SAFE/SANE are provided at no financial cost to the youth. The PAQ indicated no SAFE/SANE exams have been necessary since the last PREA audit.

(d): The auditor reviewed the MOU between Giddings and the Bastrop Family Crisis Center and interviewed the Executive Director of the crisis center who stated that the MOU was in place and the following services would be provided:

- SAFE/SANE examinations at the local hospital
- Accompany youth to the examination and during investigation
- Advocacy services through the hotline
- Twenty-four on-call staff
- Counseling services

Per the MOU, “the number is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-sit counseling offered by TJJD.”

Gap 380.9337 states that “TJJD provides youth with access to outside victim advocates for emotional support services related to sexual abuse by making available mailing addresses and telephone numbers, including toll-free numbers of any local, state, or national victim advocacy or rape crisis organizations. TJJD also provides youth with on-site access to representatives of such advocacy organizations in accordance with GAP 385.8183.” This policy establishes the process for allowing these organizations to provide on-site information, support, and other services for TJJD youth.

The campus coordinated response plan and INS 71.01 state that the mental health professional conducts an assessment and offers crisis counseling to youth as soon as possible, accompanies the youth to the hospital, and if requested by the youth after returning to the facility, arranges independent rape crisis counseling via telephone. The Compliance Manager stated that the number for the crisis center was posted in case managers' offices and would be provided to youth if an incident occurred. A Giddings case manager said the youth was "not necessarily informed" of the number or potential services. The auditor team observed the number for the crisis center posted in case managers' offices.

One youth reported a sexual abuse during interviews said that he and a staff member had had a relationship, that the staff member "was paying him to keep quiet" and that the staff member no longer worked at Giddings. He said the facility "found out" but he "kept denying it" and as a result was not offered and did not receive a mental health consultation, medical services, or outside victim advocacy and was unaware of any outside resources. He said he would like to be screened for sexually transmitted diseases (STDs). During the exit meeting, medical and mental health services were requested on the youth's behalf.

The campus criminal investigator who stated the case was originally cleared as not sustained said the investigation was reopened once additional information became available and the youth became cooperative and that the investigation is currently underway. The Compliance Manager stated that since the youth initially denied the allegation, he was not offered mental health or medical services. Additional details are discussed below in Standard 115.364.

(e): A list of mental health professionals was provided as potential staff members who were available to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. Their training is discussed below in provision (h). The outside crisis center's phone number was posted in all case managers' offices. The Compliance Manager stated that these services were offered to the best of the campus's means and as quickly as possible.

The youth whose case is currently under investigation stated that he was not offered medical or mental health services and said that he had initially denied any sexual contact. The Compliance Manager stated that once the youth admitted to the misconduct, the case was referred to OIG and the youth was informed by his dorm supervisor that he could submit a sick call if he would like to receive STD testing. After the on-site audit, during the phone interview with the facility Superintendent, she stated the youth was seen by a nurse in the infirmary and reported sexual contact with a female JCO.

(f): As indicated above in provisions (a) – (e), TJJD policy addresses each requirement of this standard. Although the OIG is considered an outside investigating entity, TJJD policy outlines the responsibilities of the OIG.

(g): The auditor is not required to audit this provision.

(h): The auditor reviewed the personnel records of one mental health professional and one medical staff member to ensure background checks were conducted per policy and to confirm they received the annual and refresher PREA-related training that is required of all Giddings' staff members. No documentation regarding their training in forensic examination issues was provided.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require: a) following a uniform evidence protocol for obtaining usable physical evidence; b) using a developmentally appropriate protocol based on *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*; c) offering forensic medical examinations at no cost to the resident; d) attempting to make outside victim services available; e) providing a qualified victim advocate to accompany residents through the examination process; f) requesting the investigating agency follow the requirements of this standard; and g) ensuring the staff member who serves in this role is screened and receives education regarding sexual assault and forensic examinations. The auditor determined TJJD policy contains the requirements of all provisions of this standard except (d) and (e).

Staff members' overall knowledge regarding the collection of evidence and actions to be taken following an allegation of sexual abuse supported compliance with provisions (a) and (b). Additional evidence supporting compliance with these provisions includes the facility's use of the National Institute of Corrections: *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* for investigator training and certificates of completion of this training.

The emergency room supervisor at a local hospital stated that the hospital employed one SANE nurse who confirmed SAFE/SANE exams would be offered to Giddings youth, which demonstrated compliance with provision (c). During interviews, youth were unaware of outside services; therefore, they would not be able to request the services as policy dictates. The coordinated response states that youth would not be offered the service until they return from the exam, which does not align with TJJD policy.

According to GAP 38.9337, these services are offered and youth are made aware of phone numbers and addresses of the services, which demonstrated compliance with provision (d). However, the campus coordinated response plan and INS 71.01 state that the youth would be offered the services after returning to Giddings from the exam, not prior to the exam.

The facility entered into an MOU with an outside victim advocate/crisis service, which demonstrated compliance with provision (d); however, the MOU states that the number would be

provided to the victim only if he/she refused in-house services. The Compliance Manager's knowledge of this process and the procedures for transporting residents to the examination as prescribed in TJJD policy and the coordinated response supported compliance with provision (e).

The auditor determined compliance with provision (f), as the OIG, the entity that conducts criminal investigation, is required to adhere to provisions (a) – (e) as outlined in TJJD GAP. Giddings' staff members who would accompany youth to forensic examinations and provide victim services have received relevant and appropriate training, which supports compliance with provision (h).

Since the auditor determined Giddings did not demonstrate compliance with provisions (d) and (e), the facility did not meet the requirements of this standard, and a corrective action was initiated.

Corrective Action:

1. Amend the MOU with the crisis center to indicate that their services will be offered to all victims of sexual abuse regardless of whether the victim refuses on-site counseling services offered by TJJD.
2. Amend the coordinated response plan and revise policy to require that the services of the crisis center are offered early enough so that one of their advocates can accompany and support the victim through the forensic medical examination process and investigatory interviews, if the victim chooses.
3. Provide training to staff members regarding the changes to the coordinated response plan so that they are aware the services of a crisis center should be offered to the victim prior to the exam.

Corrective Actions Taken since the Interim Audit Report:

The Compliance Coordinator provided the newly executed MOU, which included the signatures of the Director of the Bastrop Family Crisis Center, the Executive Director of TJJD, and a TJJD attorney. The MOU indicates that all youth "near [the] organization will be given and currently have access to your rape crisis hotline number." The MOU no longer states that youth will only be offered these services once they have refused in-house counseling.

The PREA Coordinator provided the modified campus coordinated response plan. In the original plan, one of the duties of the facility medical and mental health practitioners was to arrange for independent rape crisis counseling via telephone upon the youth's return from the off-campus forensic examination. The revised plan states that the medical and mental health care staff shall arrange for these services if requested by the youth and no longer stipulates that the services would be offered once the youth returns to the facility. Additionally, a new section titled Victim Advocacy Services outlines the services to be provided a youth who requests them and states that

these will be provided by a local rape crisis center if one is available. If one is not available, the services will be provided a qualified TJJD staff member. During interviews, the facility psychologist said that a mental health professional (MHP) was on call at all times every day. She stated that if a sexual assault occurred, the MHP would be notified and if the OIG determined a SAFE/SANE exam was needed, the MHP would accompany the youth to the exam and explain the services and availability of the rape crisis center regardless if the youth accepted or declined being accompanied by the Giddings MHP.

Additionally, the Compliance Coordinator provided an update to TJJD Institutional Operations Manual (INS.71.01), which initially noted that the MHP would conduct an assessment and offer crisis counseling to youth as soon as possible, would accompany the youth to the hospital, and if requested by the youth after returning to the facility, arrange for independent rape crisis counseling via telephone. The revised language does not stipulate that these services would be offered upon the youth's return; rather, the new language stipulates that the MHP "asks the youth who experiences sexual abuse if the youth wants a victim advocate to accompany the youth through the forensic medical examination and investigatory interviews."

Training sign-in sheets including the staff member's name, signature, title, and facility were reviewed and indicated all staff members received and understood the training titled PREA-Coordinated Response Plan. During interviews, staff members stated they received and understood this training.

Based on the revisions contained in the newly executed MOU, operations manual, coordinated response, and knowledge demonstrated in follow-up interviews with the facility MHP and leadership, the auditor determined the facility meets the requirements of this standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQs
2. GAP 380.9337 (f), (k)
3. Administrative investigative reports

Interviews:

1. TJJD Executive Director
2. Investigative staff members
3. TJJD website: <http://www.tjjd.texas.gov/>
4. Human Resources Code Chapter 242:
<https://statutes.capitol.texas.gov/Docs/HR/htm/HR.242.htm>

Observations: No observations relative to this Standard were required.

(a): The OIG is responsible for conducting criminal investigations for TJJD, and AID is responsible for conducting administrative investigations. TJJD policy outlines the responsibility of the OIG to review all allegations of sexual abuse and harassment and assign each allegation to the appropriate TJJD department to complete a criminal or administrative investigation. Policy also states that OIG investigations must be documented in a written report that includes descriptions of evidence, credibility assessments, and findings. A uniform evidence protocol, *National Protocol for Sexual Assault Medical Forensic Examinations*, Second Edition, April 2013, is used to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

TJJD policy also outlines the responsibility of the AID when conducting investigations of sexual abuse to include an effort to determine whether staff actions contributed to the abuse and documentation in a written report that includes descriptions of evidence, credibility assessments, and findings.

The Executive Director said that all investigations must be completed and described the process as:

- All staff must report all allegations to the IRC
- Each IRC report is reviewed by an experienced peace officer (OIG)
- OIG forwards the complaint to AID
- AID and OIG investigations occur simultaneously
- Once the investigation concludes, summaries are forwarded to the PREA Coordinator

Three reports that were called into the IRC which were referred to AID resulted in AID investigations. The full reports were reviewed and included the following:

- Suspect, victim, witnesses, location
- Policy violation allegation
- Details of the allegation
- Interviews information
- Evidence
- Justification of findings
- Notification to youth, staff member, and youth's DFPS case worker

The OIG and AID PAQs indicated that one criminal and one administrative investigations have not been completed. Since the OIG is considered an outside investigation entity, information regarding the incomplete case was not reviewed. The one AID case was pending as of the date the PAQ and has been completed and has since been closed within the 90-day timeframe. The AID Director confirmed that the one case requiring an extension was closed within 70 days but required the extension pending supervisory review. The table below includes information as indicated in the initial PAQ.

Giddings, OIG, and AID reported the total number of allegations of sexual abuse and sexual harassment received over that past 12 months on their respective PAQs. This information is contained in the table below.

	Facility	AID	OIG
115.322 (a)-2 Number of Allegations Received	Not answered	63	127
115.322 (a)-3 Number resulting in administrative investigations	Not answered	63	Not answered
115.322 (a)-4 Referred for criminal investigation	Not answered	Not answered	75
115.322 (a)-5 All criminal/administrative investigations were completed	Not answered	No	No
115.352 (d)-2 Number of grievances/complaints filed	0	63	Not answered
115.352 (d)-3 Number administrative investigations completed within 90 days	0	61	Not answered
115.352 (d)-4 Number of administrative investigations requiring an extension	Not answered	1	Not answered
115.364 (a)-2 Number of allegations that a resident was sexually abused/assaulted	0	63	Not answered
115.371 (i)-2 Number of sustained allegations referred for prosecution	Not answered	Not answered	3
115.373 (a)-2 Number of criminal/administrative investigations completed by the agency	Not answered	62	65
115.373 (a)-3 Of the criminal/administrative investigations completed, the number of youth who were notified of the investigation results	Not answered	Not answered	Not answered
115.373 (e)-3 Number of notifications to youth pursuant to this standard	3	Not answered	Not answered
115.378 (a)-3 Number of administrative findings of youth-on-youth sexual abuse	5	Not answered	Not answered
115.378 (a)-4 Number of criminal findings of youth-on-youth sexual abuse	Not answered	Not answered	Not answered
115.386 (b)-2 Number of criminal/administrative investigations excluding unfounded	Not answered	13	27

(b): TJJD policy requires that all allegations of sexual abuse or harassment are reported to the TJJD OIG, which reviews, assigns, and documents each allegation. Policy governs both administrative and criminal investigations and is posted on the TJJD website. Details of the OIG's authority are described in provision (a) and in the Pre-Audit section above. During interviews, investigative staff supported compliant investigative practices. IRC reports provide evidence that allegations were referred to the OIG and AID for investigation.

(c): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

(d): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

(e): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the agency ensures that an investigation is completed for all allegations, b) the agency ensures allegations are appropriately referred for investigation and this information is public, and c) if a separate entity conducts criminal investigations, the publication describes those responsibilities.

The auditor determined the policy includes each element, which supports compliance with provisions (a) – (c). The auditor reviewed three administrative investigative reports, which provided evidence of compliance with provision (a). The TJJD Executive Director demonstrated knowledge of the investigation process during her interview, which provided additional evidence of compliance with provision (a). Since all administrative investigations were completed, compliance with provision (a) was achieved. The OIG and AID investigators demonstrated their knowledge of investigation procedures during interviews, which supported compliance with provisions (a) and (b). A determination of compliance with provisions (b) and (c) was made following the auditor's review of TJJD policy to confirm investigative responsibilities were appropriately described and by visiting the TJJD and OIG website to confirm the agency publishes the policy. The facility demonstrated compliance with all provisions and thus meets the requirements of this standard.

Corrective Action: None

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. PREA and Preventing Sexual Misconduct staff development lesson plan with course description, performance objectives, and materials
4. Direct Care Staff New Hire Development: Juvenile Health lesson plan
5. OJT Juvenile Health lesson plans
6. PREA Training and Acknowledgment Form and Sign-In Sheet for Annual Training of medical and mental care staff
7. Meeting the Needs of Gender-Diverse Youth training PowerPoint
8. Relational Language Handout
9. Sign-in sheets for "Cross-Gender Script" training

Interviews:

1. Medical and mental health care staff members
2. Random staff members

Observations:

1. Interactions between staff members and youth

(a): TJJD policy requires that all staff members who may have contact with youth attend training that addresses each of the 11 elements in this subsection. During interviews, medical and mental health care staff and random staff members reported they had been trained on each element during new-hire and annual refresher training and received PREA-specific trainings during dorm meetings, which training sign-in sheets confirmed. On site, the auditor reviewed the TJJD online PREA assessment results of medical staff members and the NIC certificates of completion for medical and mental health staff members. Multiple lesson plans and training materials were uploaded and address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse. The following items were provided:

- Individual dorm training - PREA-related procedures, PREA Protocol Review, PREA and Sexual Misconduct, Zero Tolerance for Sexual Abuse, Sexual Activity, and Sexual Harassment
 - Emails from the Compliance Manager sent to dorm supervisors requesting them to add PREA-related information to their pod meeting agendas and collect training sign-in sheets
 - Sign-in and acknowledgement of understanding forms over the last 12 months, which include the staff members' names, titles, and signatures
 - Topics – types of searches permitted, restroom and shower routine, and knock and announce
- Annual training – PREA and Zero Tolerance
 - Sign-in forms over the past 12 months
 - Lesson Plans
 - Presentation materials including one specific to trauma in LGBT youth
 - Medical staff member sign-in sheets
- Refresher training - PREA/Prevention of Sexual Misconduct
 - Sign-in forms from June and August 2017
- Cross-gender Pat Search and Transgender Pat Search
 - Training script regarding these searches
 - Sign-in forms
- New-hire training - PREA and Preventing Sexual Misconduct
 - Sign-in forms over the past 12 months
 - Lesson Plan
- PREA Refresher training from January to March 2018 following an incident at another TJJD secure facility involving multiple staff members being charged with felony offenses and/or being sentenced to prison for improper sexual activity
 - Email thread between the facility and the central office staff regarding the nature of the training
 - Sign-in forms
- Meeting the Needs of Gender-Diverse Youth PowerPoint, which discusses vocabulary such as gender expression and transgender, pronouns, accommodations, treatment-related problems, and gender inclusiveness

(b): The training materials are tailored to the unique needs of juveniles and although the training materials are not gender-specific, they are appropriate for males and females. Additionally, the facility only houses males. The provided Relational Language handout includes brief strategies for communicating with female juveniles but does not appear to be gender-specific other than

using the words *her*, *she*, and *girl*. TJJD policy requires additional training if an employee is reassigned from a facility that houses only male youth to a facility that houses only female youth.

(c): The facility reports that 350 employees are currently employed by the facility who may have contact with youth, all of whom were trained or retrained on the PREA requirements outlined in provision (a).

(d): Sign-in and acknowledgement of understanding forms were provided for all trainings except the Meeting the Needs of Gender-Diverse Youth PowerPoint presentation. TJJD policy requires that training and the employees' receipt and understanding of PREA training is documented on the agency sign-in and acknowledgement form.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) employees receive training on 11 specific topics; b) the training is unique to the characteristics of the facility and additional training is provided when a staff member transfers from a male to female living unit, or vice versa; c) training remains current and refresher training occurs every two years; and d) training is documented.

The auditor determined TJJD policy contains each of the 11 elements pursuant to provision (a), which supports compliance with provisions (a) – (c). The auditor interviewed random and medical and mental health care staff and concluded they received, understood, and communicated sufficient knowledge about the 11 items during annual and refresher training. The auditor observed female staff members following PREA guidelines when entering male dorms, as they announced their presence when entering. The auditor also observed staff members communicating professionally with youth. The auditor reviewed the training curricula and determined the topics are applicable to the characteristics of Giddings in that the training is juvenile-specific, which supports compliance with provision (b). The auditor reviewed training records and signature sheets to confirm employees received and acknowledged they understood the initial and refresher training, which meets the requirement of provision (c). Since the facility demonstrated compliance with each provision, the auditor determined Giddings meets the requirements of this Standard.

Corrective Action: None

Recommendation:

1. Not all staff members could articulate how to communicate effectively with LGBT youth and were unclear about the difference between transgender and cross-gender. Provide additional training regarding communication with LGBT youth and definitions specific to this group.

Corrective Actions in Response to the Auditor's Recommendation:

The facility Compliance Manager stated and provided evidence that she recently completed an online training course titled *Gender and Sexuality: A Changing Perspective*. She stated the training was now listed as required for all staff members. The auditor reviewed the participant guide, which included information regarding LGBTI youth, an explanation of SOGIE, misconceptions, and other relevant information regarding this population.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action

recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. Training records

Interviews:

1. Volunteers who have contact with youth
2. Contractor who has contact with youth

Observations: No observations relative to this Standard were required.

(a): TJJD policy requires that all volunteers and contractors who have direct access to youth are trained on and understand their PREA-related responsibilities and procedures. The facility reported that 135 volunteers and four contractors who have such access have been trained. During interviews, the two volunteers and one contractor reported receiving a three-hour training on their responsibilities regarding sexual abuse prevention, detection, and response. They said they were trained on the facility's zero tolerance policy, how to make a report, what should be reported, and to whom to report. They said the training was provided when they first gained access to the campus but have not received refresher trainings. The sign-in and acknowledgement of understanding forms indicate volunteers and contractors received a two-hour PREA orientation training.

(b): The facility reported that the level and type of training the volunteers and contractors receive is based on the services they provide and level of contact with youth. The sign-in and acknowledgement of understanding forms indicate volunteers and contractors received a two-hour PREA orientation training.

(c): Volunteer and contractor sign-in and acknowledgement of understanding forms indicate they received a two-hour PREA orientation training.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) volunteers and contractors who have contact with residents receive training, b) the level of training is based on the service provided and level of contact, and c) the training is documented. The auditor determined that TJJD policy addresses all of the required elements, which support compliance with provisions (a) – (c). The auditor interviewed two volunteers and a contractor to confirm they received and understood the PREA-related training, which support compliance with provision (b). The auditor reviewed the training signature sheets

to confirm training was documented and maintained, which supports compliance with provision (c). Based on the interview responses and documentation review, the auditor determined sufficient evidence was present for each provision, and thus the facility meets the requirements of this standard.

Recommendation:

1. One contractor stated that her training was provided when she first gained access to the facility in 2005 and has not received refresher training. The auditor recommends providing periodic PREA-related updates to all volunteers and contractors.

Corrective Action: None

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)
3. Intake records including youth education
4. PREA Orientation and Acknowledgement Form
5. Youth handbook
6. Hotline posters in dorms and other areas across campus

Interviews:

1. Intake staff
2. Random youth

Observations:

1. Posters containing PREA-related information

(a): All youth committed to the TJJD begin their stay at the RJSJCC O&A unit. Agency policy requires that youth receive comprehensive, age-appropriate information about TJJD's zero-tolerance policy and how to report incidents of sexual abuse or harassment. Each time a youth transfers to a different TJJD facility, he or she receives the same information. The facility reported and a memo from the Superintendent stated that in the last 12 months, all 264 youth received the comprehensive PREA education. The auditor reviewed eight electronic intake records prior to the audit and eight youth master files on site that corresponded to the youth interviewed. Each file included the Youth Orientation Checklist, PREA Orientation Training and Acknowledgment Form, and receipt of youth handbook form. Also present were dated youth and staff witness signatures confirming youth participation in PREA education during the process. Zero tolerance posters in Spanish and English were displayed throughout the campus. Intake staff members said that they provided youth with PREA-related information and how to report incidents of sexual abuse or harassment. They described the process as including reading the PREA script, requiring youth to view the PREA video, explaining the locations of zero-tolerance posters. All but one youth reported receiving information about their right to be free from sexual abuse or harassment, reporting options, and the right not to be punished for reporting. They said they received the information during intake at RJSJCC and on the first day they arrived at Giddings. The one youth mentioned above said that he did not recall receiving the education

when he first arrived, but could articulate the facility's zero-tolerance policy and how to report sexual abuse or harassment.

(b): TJJD policy requires that within 10 calendar days of admission to the O&A Unit, TJJD provides comprehensive, age-appropriate education to youth about 1) their right to be free from sexual abuse or harassment and retaliation for reporting such incidents and 2) TJJD policy and procedures for responding to such incidents. During interviews, intake staff members stated that on the first day of arrival, they read the English or Spanish version of the PREA Orientation Script to youth and show the PREA video, *Safeguarding Youth Sexual Safety PREA Orientation*. The staff members said they ask follow-up questions to ensure the youth comprehends the information. Once youth are assigned to a dorm, they watch the video again, and dorm staff members provide additional PREA education. Youth corroborated this practice during interviews and said they received the education and watched the PREA video during intake once assigned to a dorm and multiple times in the dorm thereafter.

(c): TJJD policy requires that TJJD provide the PREA education each time a youth transfers to a different TJJD-operated facility. Staff and youth interviews supported compliance with this practice.

(d): TJJD policy requires that the agency provide PREA information in formats accessible to all youth including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills. The PREA script and youth handbook contain PREA-related information accessible to all youth. These documents are discussed in Standard 115.316.

(e): TJJD documents youth participation in PREA education by requiring youth to acknowledge their understanding by signing and dating the PREA Orientation Acknowledgment Form. The intake records included the Youth Orientation Checklist, PREA Orientation Training and Acknowledgment Form, and receipt of youth handbook form. Also present were dated youth and staff witness signatures showing youth participation in PREA education during the intake process. Shift logs document subsequent PREA-related training that occurs in the dorm. During interviews, staff and youth said they participated in PREA-related training and groups and frequently watch the PREA video in the day area of the dorm.

(f): PREA information is available and visible to youth through posters and youth handbooks in English and Spanish. The auditor team noted the posters were visible in dorms and common areas during the facility inspection. Youth said they received PREA-related information during intake and continuously throughout their stay.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) during intake, residents receive PREA-related information in an age-

appropriate manner; b) within 10 days, residents receive comprehensive age-appropriate PREA education; c) current residents who have not received PREA-education, shall be educated within one year; d) education is provided in accessible formats; e) resident education is documented; and f) key information is available and visible.

The auditor determined policy addresses each provision. A review of intake records, youth signature sheets, and the youth handbook, demonstrated that the facility is compliant with provision (a) because the information is comprehensive. The auditor used the leveling tool described in Standard 115.316 to measure the age-appropriateness and readability of the written material contained in the orientation packet and determined the material to be written at a level that is not accessible to all youth. However, an insert is placed in the handbooks of youth with low reading skills and youth or who have a disability. Youth with these designations reported receiving and understanding the PREA education they received, which provided the auditor with sufficient evidence of compliance with provision (a). The auditor determined compliance with provision (b) based on the facility's practice of exceeding the requirement to provide comprehensive education within 10 days of intake. The auditor verified this practice by asking questions during youth and the intake staff member interviews and by checking the date of intake against the date of youth signatures acknowledging the education was provided. The auditor determined compliance with provision (c), as the facility reported that all youth had received the education. Additionally, all but one youth interviewed reported receiving the education, and all files reviewed contained documentation of the education. The same method for Standard 115.316 and provision (a) of this standard was used to determine compliance with provision (d); the auditor concluded that the insert mentioned in provision (a) provided sufficient evidence that written PREA information is in a format that is accessible to youth with disabilities and/or low reading skills. The youth signature sheets provided evidence for the auditor to determine compliance with provision (e). During the facility inspection, the auditor team noted the placement of posters containing PREA-related information that were visible in dorms and other common areas. Since the facility demonstrated compliance with all provisions, the auditor determined that Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations

in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☐ Yes ☒ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)

Interviews:

1. Investigative staff
2. TJJD AID training agenda and lesson plan
3. Certificates of Completion of NIC Training

Observations: No observations relative to this standard were required.

(a): In addition to the general PREA training, TJJD policy requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims. The auditor verified the AID and OIG facility investigators' certificates of completion of *PREA: Investigating Sexual Abuse in a Confinement Setting* by the NIC. The two investigators interviewed stated they received this training, which included interviewing techniques, evidence collection, and use of Miranda and Garrity warnings.

(b): TJJD policy requires investigator training to include the elements of this standard. The facility provided the following for review:

- Lesson plan and PowerPoint for course titled Conducting Quality Investigations
- Interview and Interrogation PowerPoint
- The OIG Standard Operating Procedures
- Sexual Abuse Investigations lesson plan and PowerPoint
- Certificates of completion of the *PREA: Investigating Sexual Abuse in Confinement Setting* by the NIC for all investigators assigned to Giddings

The two investigators interviewed said they received the training above, which including Miranda and Garrity warnings. The AID investigator said he would use the Garrity warning for any staff members under administrative investigation, and the OIG investigator stated OIG would use Miranda when a staff member is the suspect.

(C): The auditor verified certificates of completion of the required training for the AID and OIG facility investigators.

(d): This subsection does not apply; the agency is responsible for conducting administrative investigations. The OIG conducts criminal investigations.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) facility investigators receive additional training in conducting investigations, b) the training contains specific elements, and c) the completion of the training is documented.

The auditor concluded each element of this standard is sufficiently referenced in policy, which supports compliance with provisions (a) – (c). The auditor reviewed certificates of completion of the NIC investigation training and local training materials, which provide additional evidence of compliance with provisions (a) – (c). Further compliance was demonstrated during interviews of the AID and OIG investigators as they provided details about and communicated understanding of the training they received. Compliance with provision (c) was determined based on the certificates of completion provided to the auditor. Since the facility demonstrated compliance with all provisions, the auditor concluded Giddings meets the requirements of the standard.

Corrective Action: None

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this Standard either from the agency or elsewhere? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ

2. GAP 380.9337(g)
3. Certificates of completion of PREA training
4. Training records in personnel files

Interviews:

1. Medical and mental health care staff

Observations: No observations relative to this Standard were required.

(a): TJJD policy requires that full- and part-time medical and mental health staff are trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond to victims of sexual abuse, and report allegations or suspicions of sexual abuse. Certificates of completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for Giddings mental and medical health practitioners. An Annual PREA Training Acknowledgment Form and Sign-in Sheet included signatures indicating attendance and understanding of the training. Medical and mental healthcare staff members said they received new hire and annual PREA-related training at Giddings.

(b): This subsection is not applicable; TJJD policy requires that an off-site SANE/SAFE nurse conduct forensic medical exams.

(c): The auditor reviewed documentation to verify that medical and mental health care staff received appropriate PREA training. In addition to the NIC online training, all staff members attend annual training, which includes PREA-specific topics.

(d): TJJD policy requires that full- and part-time medical and mental health staff are trained in each of the 11 required elements outlined in Standard 115.331 (a). Lesson plans address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse. Certificates of Completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for mental and medical health care staff members. During interviews, medical and mental health care staff reported they had been trained on each element during new hire and annual refresher training and received PREA-specific trainings at the facility.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) medical and mental health care staff members receive PREA-related training, b) medical staff who conduct forensic examinations receive PREA-related training, c) the training is documented, d) medical and mental health care staff members receive training pursuant to Standard 115.331 and/or 115.332. The auditor determined each element of this standard is addressed in policy, which supports compliance with provisions (a) – (d). The signature sheets acknowledging the receipt and understanding of the training received by medical

and mental health care staff members as well as the responses given during interviews led the auditor to a determination of compliance with provision (a). Provision (b) was not applicable, as the auditor confirmed forensic examinations are conducted off site. The auditor determined compliance with provision (c) because the signature sheets provided prior to the onsite audit and those observed in personnel files confirmed medical and mental health care staff received and understood the training. Additional signature sheets confirmed that all staff members, including medical and mental health care staff received training pursuant to Standards 115.331 and 115.332. Since the auditor concluded the facility is compliant with each provision, Giddings meets the requirements of this standard.

Corrective Action: None

SCREENING FOR RISK OF SEXUAL VICTIMIZATION ABUSIVENESS

AND

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No
- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained: During classification assessments? ☒ Yes ☐ No
- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this Standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes
☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. PAQ
2. GAP 380.9337 (h)
3. Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization form
4. Exit staffing overview form
5. Safe Housing Assessment/Reassessments in the Correctional Care System (TJJD online database)
6. Paper copies of the safe housing assessments

Interviews:

1. Random youth
2. Staff responsible for risk screening
3. Compliance Manager
4. Compliance Coordinator

Observations:

1. Area where resident files are stored

(a): TJJD policy requires that within 72 hours of intake and periodically throughout their confinement, an objective assessment is used to obtain information about each youth's history and behavior to reduce the risk of sexual abuse by or upon another youth. Policy also requires that information from the screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments. A safe housing reassessment is also completed upon facility transfer, at least once every 90 days, automatically within one day of a major rule violation proven true in a hearing, turning age 17, or following a serious suicide attempt. The facility reported on the PAQ that 264 youth entered the facility in the past 12 months and that all were screened for risk of sexual victimization or perpetration. Safe housing assessments and reassessments were reviewed prior to and during the on-site audit. A current safe housing report was uploaded and indicated that all youths' assessments were current. The Compliance Manager said that case managers conduct the assessments and submit them to her once completed. The digital versions in the agency database did not contain responses for all 11 items. During an informal interview, the Treatment Program Specialist of the Division of State Operated Programs and Facilities stated that fields with no responses did not indicate the question was not asked, rather, blank fields indicated the youth did not answer the question with a 'yes' response. Ten digital safe housing reassessments were reviewed. Each appeared thorough and contained case manager notes in each field that pertained to the youth.

The Exit Staffing Overview memo describes the weekly process that occurs in the intake unit within 21-28 days following each youth's commitment. The meeting is held to determine and designate the most suitable facility. A discussion takes place involving a mental health specialist, the youth's case manager, an educational representative, and a member of the Centralized Placement Unit.

During interviews, a case manager responsible for risk screenings reported using the information from the intake-screening tool and the additional safe housing assessment to make room assignment decisions. She said she uses the form, which contains the 11 items per this standard and asks youth each question on the first day they arrive, and again if additional information is reported. She said she screens the youth in the dorm or the security unit and conducts reassessments every 90 days unless additional information is received or criteria for a reassessment sooner than 90 days are met. All youth reported being asked all of the 11 items during intake at the orientation unit and again on the first day of arriving at Giddings. Only two youth said they were asked the questions on other occasions throughout their placement in TJJD; however, all reassessments reviewed included a case manager statement reporting that the youth was asked questions related to items 2 and 10 pursuant to provision (c).

(b): The auditor reviewed each assessment and determined the intake assessment, safe housing assessment, and safe housing reassessment are objective screening instruments.

(c): The intake assessment and reassessment forms are used to obtain the 11 items per this standard. The staff member responsible for the screening could articulate a few details of the items the risk screening considers.

(d): The staff member who conducts the screening said she asks the youth questions from the screening during a conversation in the dorm or the security unit.

(e): TJJD policy establishes appropriate controls to prevent sensitive information obtained from these screenings from being exploited to the youth's detriment by staff or other youth. During interviews, facility staff members stated the information from the screenings is password protected and limited to medical and mental health care staff, the youth's case manager, and supervisory staff.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the resident's history is reviewed within 72 hours and periodically, b) the assessment is objective, c) the agency ascertains information about each of the items per this provision, d) the information is ascertained through conversation and records review, and e) the dissemination of information is controlled.

The auditor determined that each element of this standard is addressed, which supports compliance with provisions (a) – (e). Although not all youth reported being asked these questions throughout their stay at Giddings, the auditor reviewed 10 risk assessments and concluded the assessments were conducted during intake and throughout the youth's confinement, which supports compliance with provision (a). The assessment procedures appear to be conducted in a similar manner for each youth, which supports compliance with provision (b). The auditor compared the assessment to the items in provision (c) and determined that each item is addressed, which supports compliance with this provision. During interviews, the case manager and youth reported that the intake process includes gleaning information through conversation. The case manager reported that a variety of data is reviewed and considered, which supports compliance with provision (d). Compliance with provision (e) was determined based on the area with limited access in which youth files are stored. Since the facility demonstrated compliance with all provisions, the auditor determined the facility meets the requirements of this Standard.

Corrective Action: None

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No
- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this Standard)? ☒ Yes ☐ No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA
- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be

included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(h)(2)
2. GAP 380.9745 (d)(2)
3. GAP 380.9739
4. Exit Staffing Overview

Interviews:

1. Compliance Manager
2. Staff responsible for risk screening

Observations:

1. Dorm assignment of an LGBT youth

(a): TJJD policy requires that information obtained using the screening instrument is used to reassess housing and supervision assignments. The Compliance Manager and staff member responsible for risk screening stated the screening instrument along with the youth's age and treatment needs is used to make dorm and room assignments. The Compliance Manager said the Institutional Placement Coordinator reviews the screening tool and assigns the youth to a dorm and appropriate bed rating of high, medium, or low risk. A dorm census report showed that youth were assigned a rating of high, medium, or low, and the safe housing reassessments in the TJJD database included case manager notes indicating the youths' risk level was considered because specific beds were assigned that corresponded to the youth's rating. Available on site were email threads between the placement coordinator, medical and mental health care staff, case managers, education staff, and administrators showing changes in risk levels and subsequent housing and bed changes.

(b): TJJD policy requires that 1) except under limited situations involving self-injury, TJJD does not place youth in isolation as a means of protection, 2) the placement of youth in protective custody is used only as a last resort, and 3) youth in protective custody receive all standard service delivery and programming requirements. The facility reported that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(c): TJJD policy requires that LGBT youth are not placed in particular housing, beds, or other assignments on the basis of such identification. During interviews, the youth who identified as questioning reported not being placed in a dorm based on this status. His room assignment was observed during the facility inspection and confirmed that he was not placed in a dorm or room based on his status. Interviews with staff verified compliance with this practice.

(d): TJJD policy requires that for each transgender or intersex youth, TJJD makes a case-by-case determination when assigning the youth to a male or female facility. The audit found that no youth who identify as transgender or intersex were placed at the facility during the on-site audit portion. However, in the past 12 months, one youth who identified as transgender was placed at the facility. The PREA Compliance Manager said all decisions were made on a case-by-case basis. She said housing decisions were made based on the screening reassessment data and the youth's age and treatment needs. Although no transgender youth was present at the facility, one transgender female was assigned to Giddings in the past 12 months. Documents related to this youth were reviewed and included general youth data, offense history, initial safe housing assessment, cognitive functioning, re-entry planning, and placement decision. The initial assessment stated that the youth admitted gender confusion, sometimes preferred to be called by a female name, and preferred to be housed with males. An email thread contained discussions about how to conduct pat searches on this youth; additional details are in Standard 115.315. The questioning youth said he did not recall if he was asked questions about his safety when he first arrived at Giddings but that "someone talked to him every three months for his SOGIE," which was confirmed in the TJJD database. The youth's risk rating is low, and his room is toward the back of the dorm. The youth stated that he felt his room assignment was appropriate.

(e): TJJD policy requires that placement and programming assignments are assessed at least twice per year. The Compliance Manager and staff responsible for risk screening said that youths' safety and security was considered when making dorm and room assignments.

(f): TJJD policy requires TJJD to consider the youth's own views concerning his or her own safety when making placement and programming assignments. The Superintendent, PREA Compliance Coordinator, and Compliance Manager corroborated this practice during interviews. The questioning youth said he did not recall if someone asked him about his safety upon his arrival at Giddings but that someone speaks with him every three months to gather SOGIE information.

(g): TJJD policy requires that transgender or intersex youth are provided the opportunity to shower separately from other youth. Interviews with staff verified compliance with this practice, and the questioning youth said he and all youth showered separately.

(h): The facility reported that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(i): TJJD policy exceeds the 30-day review requirement and requires that at least once every 48 hours following a youth's admission into protective custody, the designated mental health professional reviews the documentation relating to the protective custody, including the youth's treatment plan and any other documentation relating to the youth's stay in protective custody. The three staff responsible for monitoring youth in isolation/the security unit were unsure of the timeline for reviewing youth placed in protective custody, but all said it would be more frequent

than 30 days. They said that youth placed per this provision would only be placed for a few days until dorm reassignments were made.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency uses information gained pursuant to Standard 115.341 to make placement decisions designed to keep all residents safe; b) residents are isolated as a last resort and if they are isolated, resident receive access to exercise and education; c) LGBT residents are not placed in specific housing based on this status; d) placement decisions are made on a case-by-case basis; e) placement decisions for transgender and intersex youth are reassessed twice per year; f) the views of transgender and intersex residents are given serious consideration; g) transgender and intersex are given the opportunity to shower separately; h) isolation of residents is documented; and i) residents held in isolation receive a review every 30 days.

The auditor reviewed TJJD policy and determined that all provisions are sufficiently addressed, which supports compliance with provisions (a) – (i). The auditor reviewed reassessments that resulted in specific housing and bed assignments and emails between multiple staff members showing that information related to the assessment was considered and resulted in housing and bed changes, which evidenced the implementation of provision (a). Staff members' and youths' responses during interviews confirmed that isolation is not used for protective custody, thus supporting compliance with provisions (b), (h), and (i). Youth responses during interviews and verification of the housing assignments of one LGBT youth confirmed compliance with provision (c). During the interview with the questioning youth, he reported that he and all other youth showered separately, and was reassessed every three months, which support compliance with provisions (c) – (g). Since sufficient evidence was present to determine compliance with all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☐ Yes ☒ No

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)
3. TJJD Youth Handbook
4. TJJD Employee Handbook
5. Youth grievances alleging sexual abuse or harassment that staff reported to the IRC
6. Investigative reports containing evidence that verbal reports are documented and reported

Interviews:

1. Random staff members
2. Youth
3. Youth who reported a sexual abuse
4. Compliance Manager

Observations:

1. Posted hotline numbers in dorms

(a): TJJD policy requires that youth may report sexual abuse or harassment, retaliation, and staff neglect by: 1) filing a written grievance, 2) calling the OIG hotline, 3) telling a staff member, volunteer, or contract employee, or 4) calling the OIO. During interviews, youth were able to articulate the various ways to make a report, but many said they would not be able to do so privately or anonymously.

(b): TJJD policy requires that youth can make a report by “calling the toll-free number maintained by the Office of Independent Ombudsman (OIO), which is a separate state agency, without being heard by staff or other youth.” During the facility inspection, OIO and the zero-

tolerance posters were posted in dorms and other areas across campus and included the toll-free numbers. These numbers are also included in the youth handbook. The facility has an MOU with a family crisis center, but the number is posted in case managers' offices and is not accessible to youth. Additional details about access to the crisis center are provided in Standard 115.321.

During her interview, the Compliance Manager said that youth could report sexual abuse by calling the OIO who would contact the IRC and a case would be assigned. During interviews, most youth were unaware of an outside reporting option and when prompted said they could tell their "mom." Several said they could call the OIO. None were certain about submitting an anonymous report, and most said they would be required to give their name and/or TJJD number.

The agency does not house residents detained solely for civil immigration purposes; therefore, the second portion of this provision is not applicable.

(c): TJJD policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must be promptly reported. A review of serious incident reports indicated allegations received verbally and through the youth grievance system were reported by staff members to the IRC. Youth articulated an understanding of the various reporting options, but most said they would not be able to report anonymously or privately.

(d): The facility provides youth access to the tools necessary to make a written report. During informal interviews with random youth and the youth grievance clerks, they said they had daily access to grievance forms and could drop the completed grievance into one of several locked boxes located in common campus areas. The auditor team observed the OIG and OIO phone numbers posted throughout the facility. The youth involved in an ongoing sexual misconduct investigation said he provided written and verbal statements to the investigators.

(e): TJJD provides staff members the same reporting options as youth, and during interviews, they demonstrated an understanding of the ability to report anonymously and privately.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency provides multiple ways to privately report sexual abuse or harassment; b) residents are provided an anonymous reporting option to an outside entity, and residents detained for civil immigration shall be provided information on how to contact consular officials; c) staff shall accept verbal, written, anonymous, and third party reports and must document verbal reports; d) residents have the tools needed to make written reports; and e) staff have a method to privately report sexual abuse or harassment of residents.

The auditor reviewed determined that each element of this standard is included, which supports compliance with provisions (a) – (e). To support compliance with provisions (a) and (b), the auditor noted the hotline numbers posted in each dorm, conducted informal interviews with

youth and staff and asked them to point out the posted numbers and to explain reporting options. One requirement of provision (b) is to allow youth to report anonymously. Since youth were unaware of this option, full compliance with this provision was not achieved and a corrective action initiated. A determination of compliance with provisions (c), (d), and (e) was based on interview responses which included explanations of a variety of reporting options and the procedures for making reports. Additional evidence for provision (c) was contained in the incident and investigative reports. Each of these includes the documentation of verbal reports made by youth and subsequent reports made to the IRC. Since the facility did not demonstrate compliance with each provision, the auditor determined Giddings did not meet the requirements of this standard.

Corrective Action: None

Recommendation:

1. Since many youth did not know they could report anonymously, provide additional education to make them aware of this option.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this Standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this Standard.)
☒ Yes ☐ No ☐ NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this Standard.)
☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this Standard.)
☒ Yes ☐ No ☐ NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this Standard.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)
3. GAP 380.9331 (a)
4. Youth handbook

Interviews:

1. Compliance Manager
2. Superintendent

Observations: No observations relative to this standard were required.

(a): TJJD policy outlines the administrative procedures for addressing youth reports regarding sexual abuse. Policy states that a youth may report sexual abuse/harassment, retaliation, staff neglect, or violations that may have contributed to such incidents by filing a written grievance, calling the IRC maintained by the OIG, calling the OIO, or telling a staff member, volunteer, or contractor who must then call the IRC.

(b): TJJD policy requires that the OIG and/or the AID investigate all allegations of sexual abuse regardless of how much time has passed since the alleged incident. The policy also states that

youth are not required to use the grievance system or the informal conference request and are not required to attempt to resolve the allegation with staff. If a youth uses the grievance system or conference request, the allegation is immediately forwarded to the OIG for assignment and investigation. The youth handbook includes the following:

- Phone numbers for the OIG hotline and OIO
- Zero tolerance policy
- Overview of the PREA
- Definitions of sexual abuse
- Sexual abuse myths and realities
- Actions to take if a youth is abused
- Reporting options (tell a staff member, call one of the hotlines, write a grievance)

(c): TJJD policy requires that a grievance alleging sexual abuse or sexual harassment does not have to be submitted to the person who is the subject of the allegation and the allegation is referred to the staff member who is the subject of the complaint. The youth handbook contains details about the grievance process and includes information regarding the youth's right to submit a grievance.

(d): TJJD policy does not stipulate that a final decision on the merits of an allegation of sexual abuse or harassment be completed within 90 calendar days of the initial filing of the complaint. However, a directive from the Deputy Director of the AID stated "effective July 15, 2014 the AID revised the operating procedures to allow 60 business days (i.e. 90 calendar days) from the receipt of an allegation to final disposition of an administrative investigation. The investigator may request an extension up to 70 calendar days to complete the investigation. In the table below, the AID reported that one extension was required. The AID Director confirmed that this case was closed within 70 days but required the extension pending supervisory review. The table below includes information as indicated in the initial PAQ. The three AID investigations indicate a final decision was reached within 90 days of the receipt of the allegation.

(e): TJJD policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must be promptly reported. The agency grievance policy states that youth, parents/guardians of youth, and youth advocates have a right to file grievances concerning a youth under the jurisdiction of TJJD. The policy also states that any person may submit a grievance to the IRC by telephone, email, fax, or postal service. If a third party, other than a parent or guardian, files a request on behalf of a resident, the agency does not require as a condition of processing the request that the alleged victim to agree to have the request filed on his or her behalf. The auditors found no policy or documentation reviewed to contradict this. Additionally, when a parent or legal guardian files a request on behalf of a resident, the agency does not condition processing of the request upon the juvenile agreeing to have the request filed on his or her behalf. The auditors found no policy or documentation to contradict this. One third-party report was reviewed. A youth called the IRC alleging a staff member's sexual misconduct with several other youth. The allegation was referred to the AID for investigation. The investigative report included all required information as well as the notifications to all youth involved of the disposition.

(f): TJJD policy states that upon receipt of a report that alleges a youth is subject to a substantial risk or imminent sexual abuse, TJJD takes immediate action to protect the youth. The facility reported that there have been no emergency grievances alleging risk of imminent sexual abuse in the last 12 months.

(g): TJJD policy states that the “agency may not discipline a youth if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.” The youth handbook instructs youth not to lie and explains that false reports are crimes. The facility reported there have been no youth grievances alleging sexual abuse that resulted in disciplinary action by the agency against the youth for having filed a grievance.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency has administrative procedures for dealing with sexual abuse allegations; b) the agency does not impose a time limit to submit a grievance regarding sexual abuse, may apply time limits on a portion of the grievance that does not allege sexual abuse, shall not require the use of an informal grievance process, the agency’s ability to defend against a lawsuit based on the statute of limitations; c) residents may submit a grievance without submitting it to a staff member who is the subject of the complaint; d) the agency shall issue decisions about allegations of sexual abuse within 90 days; a 70-day extension may be issued; if the resident does not receive a decision within the administrative process time limit, the resident may consider the absence of a response to be a denial at that level; e) third parties may assist residents in filing administrative remedies relating to sexual abuse; if third parties other than parents or guardians file such a request, the facility may require the alleged victim to agree to have the request filed on his/her behalf; if the resident does not agree, the facility must document the resident’s decision; a parent may submit this request without the youth’s agreeing to have the request filed on his/her behalf; f) the agency shall establish procedures for the filing of emergency grievances of imminent sexual abuse and immediate action must be taken to protect the resident; and (g) residents may be disciplined for alleging sexual abuse in bad faith.

The agency is not exempt from provision (a), as the facility has administrative procedures to address resident grievances regarding sexual abuse. The auditor reviewed TJJD policy, and although the language in the policy is not in exact alignment with the language in this standard, the auditor determined that policy and the AID directive explicitly and/or implicitly addresses all elements, which demonstrate compliance with provisions (a) – (g). Compliance with provision (b) and (c) was based on the auditor’s review of the youth handbook, which contains information pursuant to these provisions. For provision (d), the three full investigative reports and the Compliance Manager’s notification documentation indicated that all decisions were reached within 90 days. However, AID reported on the PAQ that one notification was needed because a decision was not reached within 90 days. The AID Director confirmed that this case required an extension pending supervisory review and was closed within the additional 70 days. No third party or emergency reports were received during the audit period, so the auditor relied upon

agency policy and interview responses, both of which indicated third party reports would be accepted, to determine compliance with provisions (e) and (f). The auditor determined compliance with provision (g) based on policy and the youth handbook, which include information regarding these types of grievances. Since the facility demonstrated compliance with all provisions, Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No
- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)
2. MOU for the Bastrop Family Crisis Center
3. Youth handbook

Interviews:

1. Facility Superintendent
2. Director of the Bastrop Family Crisis Center
3. Random youth
4. Youth who reported a sexual abuse

Observations:

1. Posted crisis center number in case managers' offices
2. Youth phones in each dorm

(a): TJJD policy requires that youth have access to outside victim advocates for emotional support services related to sexual abuse by making available mailing addresses and telephone numbers. The Compliance Manager stated the crisis center's phone number is posted in every

case manager's office. The MOU between the crisis center and interview of the center's director indicated an agreement was established to provide services, but the service had not been utilized in the past 12 months. Per the MOU, the crisis center's phone number is provided once it has been determined that the youth in question is the victim of sexual abuse and has refused on-site counseling services offered by TJJD. The auditors reviewed the handbook, which did not include the contact information or name of an outside rape crisis center.

During random youth interviews, none were aware of outside rape crisis or victim advocate services that specifically served Giddings youth. Several named the OIO as the outside resource. While the OIO is an outside reporting option, the agency would not provide rape crisis services.

Although no youth was identified by the facility as having reported a sexual abuse, one youth who had initially denied sexual contact with a staff member stated he had participated in sexual misconduct. He said that he was unaware of outside victim crisis services. Additional included above in Standard 115.321 and on pages 12-13.

(b): TJJD policy requires that youth are informed, prior to giving them access, of the extent to which communications with outside services related to sexual abuse will be monitored and mandatorily reported. During interviews, staff members communicated understanding of mandatory reporting laws. Since youth lacked understanding of outside support services, they lacked understanding of the limits of confidentiality of these services.

(c): An MOU with a crisis center indicated an agreement was established to provide services. The auditor interviewed the Director of the center who said the service had not been used in the past 12 months by any youth at Giddings; however, she verified that the following services would be provided if needed.

- SAFE/SANE examinations at the local hospital
- Accompany youth to the examination and during investigation
- Advocacy services through the hotline
- Twenty-four on-call staff
- Counseling services

Per the MOU, "the number is distributed to youth after it has been determined that the youth in question is the victim of sexual abuse and has refused the on-site counseling offered by TJJD."

(d): TJJD policy requires reasonable and confidential access to youths' attorneys and parents or legal guardians. During interviews, youth said they received this access. The auditor team observed youth phones on each dorm, and confirmed by picking up the receiver, that the phones were operable.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall provide residents access to outside victim advocates related to sexual abuse, b) the facility inform residents of the extent to which communications are monitored and of mandatory reporting, c) the facility shall attempt to enter into an MOU with community service providers that provide residents with emotional support services, and d) the facility shall provide confidential access to legal representation. Although policy addresses each provision, based on youths' lack of knowledge of these services, and thus lack of knowledge of the limits of confidentiality, the auditor determined the facility did not demonstrate compliance with provisions (a) and (b).

The auditor relied upon interviews for additional evidence of compliance with provision (d). Staff members and youth explained that youth are consistently provided access to their attorneys and legal representation and may speak to them privately. Since the facility did not demonstrate compliance with provisions (a) and (b), Giddings did not meet the requirements of this standard and corrective action was initiated.

Corrective Action:

1. Provide, post, or otherwise make accessible the address and telephone number to the outside advocate pursuant to provision (a).
2. Per provision (b), provide youth education regarding this access, the extent to which such communications will be monitored, and the services related to sexual abuse available to them.
3. As requested in Standard 115.321, amend the MOU with the crisis center to indicate that their services will be offered to all victims of sexual abuse regardless of whether the victim refuses on-site counseling services offered by TJJD.

Corrective Actions Taken since the Interim Audit Report:

The PREA Coordinator provided documentation that all youth received education regarding the available services of a rape crisis center and a new youth orientation packet that includes the center's pamphlet, which includes the services offered, phone number, and address. During follow-up interviews, youth said that they received this information during dorm meetings, confirmed that the pamphlet was included in the orientation packet they received, and stated the center's contact information is posted in their dorms and accessible.

The Compliance Coordinator provided the newly executed MOU, which included the signatures of the Director of the Bastrop Family Crisis Center, the Executive Director of TJJD, and a TJJD attorney. The MOU indicates that all youth "near [the] organization will be given and currently have access to your rape crisis hotline number." The MOU no longer states that youth will only be offered these services once they have refused in-house counseling.

Based on the revisions contained in the newly executed MOU, operations manual, coordinated response, and knowledge demonstrated in follow-up interviews with the facility MHP and leadership, the auditor determined the facility meets the requirements of this standard.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)
2. Memo from the Superintendent regarding third party reporting to the OIO
3. TJJD website

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(a): The TJJD website provides appropriate reporting options on its website. The primary referral option is through the IRC maintained by the OIG, but reports may also be made to the OIO, law enforcement agencies, Children's Protective Services, and to the facility directly.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall have a method to receive third-party reports. Since policy contains this information, compliance with this provision is supported. For additional evidence, the auditor visited the agency website pages, which inform the public about and contain links to reporting options. The auditor determined the facility meets the requirements of provision (a), and thus this standard.

Corrective Action: None

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?
☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?
☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?
☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No
- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Employee handbook
3. Memo from Superintendent regarding staff and agency reporting duties
4. GAP 380.9337(j), (1)
5. Incident reports
6. Investigative reports
7. Psychology notification to DFPS

Interviews:

1. Superintendent
2. Compliance Manager
3. PREA Compliance Coordinator
4. Director of Nursing
5. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that staff members must immediately report to the OIG any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment. They are also required to report any incident of retaliation against youth or staff who reported such incidents as well as any staff neglect or violation of responsibilities that may have contributed to such an incident. This policy applies to any facility, whether or not it is operated

by TJJD. Interviews with staff demonstrated their knowledge of their reporting responsibilities under Texas law, facility policy, and PREA regulations.

(b): TJJD policy requires that all staff members must comply with mandatory child abuse reporting laws in the Texas Family Code and with applicable professional licensure requirements. Interviews with staff indicate they are aware of and understand mandatory reporting laws and hold required licenses.

(c): TJJD policy requires that all staff members who receive a report of alleged sexual abuse is prohibited from revealing that information to anyone other than to the extent necessary. Interviews with staff demonstrated they understand the requirements for the handling of sensitive youth information. They said they received the information during new hire, annual training, and dorm reviews.

(d): TJJD policy requires medical, mental health staff, clergy and attorneys whose communications may otherwise be privileged to report abuse as required by law and to inform youth of the limitations of confidentiality. Interviews with medical and mental health care staff confirmed compliance with this standard relating to protection of confidential information and required disclosures.

(e): TJJD policy requires that the facility administrator must promptly report any allegation of alleged sexual abuse to the youth's parents or legal guardians. If the alleged victim is under the conservatorship of DFPS, the report is made to DFPS. Four parent notification letters of the opening and closing of investigations were reviewed to support compliance with this subsection. A psychology notification to DFPS was reviewed and provided evidence that the notification was made to this entity following a youth's report of sexual conduct when he was age 5-6. A TJJD chronological record also noted this report.

(f): TJJD policy requires that all staff members must immediately report all allegations of sexual abuse and sexual harassment to the OIG. OIG assigns all reports of alleged sexual abuse and sexual harassment, including third-party and anonymous reports, to the appropriate investigator. Interviews with the OIG investigator and the Superintendent confirmed this is the practice. They stated that all reports are submitted to the IRC, which is monitored by OIG. The auditor reviewed IRC documentation to confirm that allegations of sexual abuse or harassment were reported to the designated agency's department or the OIG.

Summary of Findings:

The auditors assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall require staff to report any knowledge, suspicion, or information regarding sexual abuse, retaliation, and neglect; b) the agency shall require staff to comply with mandatory reporting laws; c) staff shall not reveal information regarding sexual

abuse incidents other than to the extent necessary; d) medical and mental health staff must report sexual abuse to supervisors, state and local agencies where required by mandatory reporting laws and inform residents of the limitations of confidentiality; e) upon receiving a sexual abuse allegation, the facility head or designee must report to appropriate agencies, and the resident's parents, caseworker, legal guardian, or legal representative; and f) the facility shall report sexual abuse allegations to investigators.

The auditor reviewed TJJD policy and concluded that each element is addressed, which supports compliance with provisions (a) – (f). Evidence relied upon to determine compliance with provisions (a) and (b) was based upon interviews with staff members who communicated an understanding of their reporting duties. Compliance with provision (c) was determined through interviews, during which staff members communicated their understanding of protecting information related to sexual abuse reports. Evidence for provision (d) was based on staff medical and mental health staff members' understanding of mandatory reporting. Compliance with provisions (d) and (e) was also based on interviews, during which staff members articulated knowledge of their reporting duties and understood to whom they would report any information regarding sexual abuse. Further evidence of compliance with provision (e) was demonstrated through a psychology report to DFPS. The auditor reviewed incident reports and investigative reports and concluded that since the verbal allegations of sexual abuse were reported to the IRC and subsequently investigated, compliance with provision (f) was evident. Since TJJD demonstrated compliance with each provision, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)

Interviews:

1. Superintendent
2. Compliance Coordinator
3. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that upon receipt of an allegation that a youth is subject to a substantial risk of imminent sexual abuse, TJJD must take immediate action to protect the youth. The agency reported that there have been no instances of this in the past 12 months. All staff members interviewed were able to explain precautions that would be taken to protect a youth at risk of imminent sexual abuse.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) when an agency learns a resident is at risk of imminent sexual abuse, immediate action to protect the resident must be taken. The auditor reviewed policy and determined this provision is addressed. Since an incident of this type did not occur during the audit period, the auditor relied on staff members' responses during interviews and assessed their knowledge regarding the actions that would be taken if this should occur. Staff members communicated an understanding of these actions per this standard and the facility coordinated response plan and were able to articulate specific and immediate actions they would take. The auditor determined the facility meets the requirements of provision (a), and thus this Standard.

Corrective Action: None

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?
☒ Yes ☐ No
- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these Standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. GAP 380.9337 (k),(1)
4. Investigation summaries
5. SARB forms

Interviews:

1. Superintendent
2. Compliance Manager

(a): TJJD policy requires that any staff member who receives an allegation that a youth was sexually abused while confined at another facility must immediately notify the OIG, and the OIG must notify the head of the facility where the abuse occurred. The auditor's interview with the TJJD Executive Director confirmed her knowledge of this requirement. The facility reported there were no allegations of this type received in the past 12 months. Although no notifications were received from other facilities in the past 12 months, one report from a former Giddings youth was received in the past 12 months. A county prosecutor contacted an OIG investigator regarding an alleged sexual assault that occurred at Giddings in 1982. The youth reported that he was the victim of sexual abuse by staff members while placed at the facility. The disposition notes and justifications were included in the documentation and indicated a criminal investigation was conducted and closed as not sustained. The subsequent SARB included the disposition of the administrative investigation conducted in reference to two staff members the youth alleged sexually abused him. The case was closed as unable to determine.

(b): TJJD policy requires that the notification will be provided as soon as possible but no later than 72 hours after receiving the allegation.

(c): No allegations were received; therefore, no notifications were provided.

(d): TJJD policy does not contain the TJJD's guidelines requiring that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) upon receiving an allegation of sexual abuse that occurred at another facility, the facility head notifies the facility head or appropriate office where the alleged abuse occurred; b) the notification shall be provided immediately but no later than 72 hours after receiving the allegation; c) the notification shall be documented; and d) the facility head or agency office shall ensure the allegation is investigated.

Since no allegations of this type were reported during the audit period, the auditor relied upon policy and interview responses for all provisions. The auditor determined that each provision except (d) is addressed in policy. The interview responses of the Superintendent and TJJD Executive Director confirmed their knowledge of documentation and reporting responsibilities when a sexual abuse allegation is received from another facility. The facility demonstrated compliance with provisions (a) – (c), but policy did not contain the elements of provision (d). However, the allegation received from a former Giddings youth and the subsequent AID and OIG investigations and SARB provided evidence that allegations received from an outside source are investigated according to TJJD and PREA requirements. The auditor determined the facility meets the requirements of all provisions, and thus this standard.

Corrective Action: None

Recommendation:

1. Revise policy that contains the requirement that allegations received from other facilities/agencies are investigated in accordance with the PREA Standards and are the responsibility of the facility where the alleged abuse occurred.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if

the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Coordinated response plan

Interviews:

1. Security staff and non-security staff first responders
2. Youth who reported a sexual abuse
3. Random staff

Observations: No observations relative to this standard were required.

(a): TJJD policy and coordinated response plan contains all of the required elements of the first responder duties outlined in this standard. Interviews with staff members indicate an understanding of their first responder duties, and all but two were able to describe the procedures that would be followed to protect the youth and the crime scene. These two were unable to

describe their first responder duties and said they would notify their supervisor and security unit staff members. The facility reported no informal grievances alleged sexual abuse, and the AID reported there were 63. Of these, none were within the timeframe that allowed for physical evidence collection.

During interviews, the youth who received notification of the closure of an AID investigation reported having sexual contact with a JCO. He said that he did not report the alleged sexual acts because he consented. He stated that he initially denied the misconduct, which was corroborated in the resulting SARB, but that the facility “found out.” He said that no one spoke with him or offered medical or mental health services, but that he would like to be tested for sexually transmitted infections, which were requested for the youth during the exit meeting. See Standard 115.321 and pages 12-13 for additional details.

(b): TJJD policy outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused. All but two staff members could articulate their first responder duties.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) upon learning that a resident was sexually abused, the first responder must separate the alleged victim and abuser, preserve the scene and collect evidence, collect physical evidence if the abuse occurred within a time period that this evidence may be collected, and ensure physical evidence is protected; and b) if the first responder is not a security staff, the responder shall request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. The auditor determined that TJJD policy and the coordinated response plan contain each of these elements, which supports compliance with provisions (a) and (b). Interviews responses revealed additional evidence of compliance, as staff members communicated an understanding of the actions they would take following an allegation of sexual abuse. Since the facility demonstrated compliance with both provisions, the auditor determined Giddings meets the requirements of this Standard.

Corrective Action: None

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Coordinated response plan

Interviews:

1. Superintendent

Observations: No observations relative to this standard were required.

(a): The facility maintains a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, on-duty supervisors, medical and mental health care staff, investigators, facility leadership, sexual abuse review board members, and the Compliance Manager. The duties outlined in the plan require the first responder to notify the on-duty supervisor, notify infirmary staff, and report the allegation to the IRC and chief local administrator. The on-duty supervisor is responsible for separating the alleged perpetrator and alleged victim and securing the crime scene. The actions outlined in GAP 380.9337 (j) require the first responder to separate the alleged victim and alleged abuser, preserve the crime scene, and take additional actions if the allege abuse occurs within a timeframe that allows for the collection of physical evidence. The Institutional Operations Manual (INS 71.01) requires actions, which align with the written institutional plan. The Superintendent demonstrated knowledge of the details in policy and the coordinated response plan.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall develop a written institutional plan to coordinate actions in response to an incident of sexual abuse. The auditor determined the facility policy contains details regarding this provision. Additional support of compliance was determined following a review of the Giddings' coordinated response plan, which includes actions to be taken by various staff members. During her interview, the Superintendent demonstrated comprehension of the plan. The auditor concluded that the facility meets the requirements of provision (a), and thus meets the requirements of this standard.

Corrective Action: None

Recommendation:

1. Revise the coordinated response plan to be specific to Giddings, such as including information regarding the name of the hospital where the victim will be transported and the name of the rape crisis center to be contacted.

Corrective Actions Taken in Response to the Auditor's Recommendation:

The Compliance Coordinator stated that the coordinated response plan would be addressed and revised to be specific to each facility in an upcoming PREA Compliance Manager Training in March 2019. All those involved with PREA-related efforts including compliance managers and administrators of TJJD facilities will be in attendance.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ

Interviews:

1. TJJD Executive Director
2. Compliance Coordinator

(a): TJJD meets the requirements of this subsection as TJJD does not enter into collective bargaining agreements that would limit TJJD's ability to remove alleged staff sexual abusers from contact with any youth pending an investigation determination.

(b): Giddings meets the requirements of this standard as the facility does not enter into collective bargaining agreements.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall not enter into a collective bargaining agreement that limits the agency's ability to remove alleged abusers from contact with residents pending the outcome of investigation or disciplinary actions. Provision (b) is not required to be audited. Since TJJD policy contains language pursuant to provision (a), and provision (b) is not required to be audited, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Documentation of monitoring retaliation
4. Coordinated response plan

Interviews:

1. TJJD Executive Director
2. Superintendent
3. Compliance Coordinator
4. Staff who monitor for retaliation
5. Youth who reported a sexual abuse

Observations: No observation relative to this standard was required.

(a): TJJD policy prohibits retaliation by a youth or staff member against a youth or staff member who reports or cooperates with an investigation. Certain staff members are designated to monitor the person who reported the allegation and the alleged victim for possible retaliation. The facility reported that there have been no incidents of retaliation that have occurred in the past 12 months.

(b): The TJJD uses multiple protection measures to protect youth and staff from retaliation, such as housing transfers, transfers of youth, removal of alleged abuser from contact with the alleged abuser, and emotional support services. Staff members were able to articulate actions utilized to protect youth and staff members and monitor for retaliation. The Superintendent said measures could include dorm transfers, bed assignment changes, implementing boundary and safety plans, utilizing the monitoring form, or reporting suspected retaliation to the IRC. The auditor reviewed completed monitoring forms, which included the youth being monitored and staff notes regarding the youth's own perception of safety. The Compliance Manager also provided an Excel spreadsheet that contained the AID, OIG, and/or IRC number; staff or youth being monitored; location and supervisor; other youth involved; allegation; the investigating entity; and the investigation status, finding, and retaliation monitoring status.

(c): TJJD policy requires the agency to continue monitoring for retaliation for at least 90 days following a report, except when the allegation is determined to be unfounded. An extension of

more than 90 days is possible if needed. The Superintendent, Compliance Manager, and staff member responsible for monitoring were knowledgeable about the duty to monitor for retaliation for at least 90 days. They said this time would be extended if needed, as there is no maximum time for monitoring efforts. Completed monitoring forms indicated compliance with the 90-day timeline, and the spreadsheet provided by the Compliance Manager evidenced monitoring efforts exceeding 90 days. The staff member who monitors for retaliation said the longest monitoring she had provided for a youth was approximately five months.

(d): TJJD policy requires that staff members conduct periodic status checks of the alleged victim. The staff member responsible for monitoring for retaliation stated there is no maximum length of time a youth would be monitored and that she conducted status checks at least once per week. Retaliation monitoring forms corroborate this practice.

(e): TJJD policy requires that staff take appropriate measures to protect any other individual who cooperates with the investigation who may be at risk of retaliation or who expresses a fear of retaliation. The Superintendent said that monitoring occurred weekly and that status updates and any actions required to provide safety were discussed during multi-disciplinary team meetings. The TJJD Executive Director said that if any individual expressed fear of retaliation, the IRC would be notified and a safety plan drafted to protect the individual.

(f): TJJD policy requires that the agency's obligation to monitor shall terminate if the investigation determines the allegation is unfounded.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency establishes policy to protect residents and staff from retaliation, b) the agency shall use multiple protection measures, c) the agency shall monitor for retaliation for at least 90 days, d) monitoring shall include periodic status checks, and e) if any individual expresses fear of retaliation, the agency takes steps to protect the individual. Provision (f) is not required to be audited.

The auditor determined that TJJD policy contains each provision, which demonstrates compliance with provisions (a)-(f). Evidence of compliance with provision (a) includes the facility's designation of staff members who are responsible for retaliation monitoring. Evidence of compliance with provisions (b) – (e), was determined after reviewing interview responses. The retaliation monitoring staff member communicated an understanding of her monitoring duties and the required timeline during her interview. The Compliance Manager, Superintendent, and Executive Director described actions that would be utilized to protect youth or staff who feared retaliation. Compliance with these provisions was further demonstrated during a review of the extensive documentation of these efforts to monitor for retaliation. Since the facility

demonstrated compliance with all provisions, the auditor determined the Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Memorandum from Superintendent documenting the facility's no isolation policy

Interviews:

1. Superintendent
2. Staff who supervise youth
3. Medical and mental health care staff

Observations: Rooms used for isolation

(a): TJJD policy prohibits using segregated housing to protect a youth who is alleged to have suffered sexual abuse. Staff interviews indicated that isolation is not used to protect youth who have alleged to suffer a sexual abuse. In a memo, the Superintendent wrote:

Giddings does not segregate youth due to sexual harassment. Youth are kept on the dorm, staff updates their CCF-036 [safe housing assessment], issues a Safety or Boundary Plan for the youth and documents any retaliation by other youth or staff by utilizing the Agency Protection Against Retaliation form.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) any segregated housing used to protect a resident alleged to have suffered sexual abuse shall be subject to the requirements in Standard 115.342. The auditor's determination of compliance with this provision was based on policy review, interview responses, and observation of the isolation rooms. The policy contains details regarding provision (a), and staff members reported that this type of segregation is not used. No youth were placed in isolation pursuant to this standard during the facility inspection. Additional support of compliance was based on youths' responses, which confirmed that this type of isolation is not used. Since Giddings is compliant with provision (a), the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. AID investigative reports
4. Notifications
5. Training records for investigators

Interviews:

1. Superintendent
2. Random staff
3. AID and OIG investigators
4. Youth who reported a sexual abuse

Observations:

1. Records storage area and electronic storage system

(a): TJJD policy requires that investigations will be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. Both investigators said that once reports, including third-party reports, alleging sexual abuse are received, an investigation would be initiated within 24 hours. Three AID investigative records, including one regarding an allegation submitted by a third party, appeared thorough and contained a summary, preliminary findings, case detail including each action taken during the investigation, victims, witnesses, suspects, physical evidence, and investigative results.

(b): TJJD policy requires that it will use investigators who have received special training in sexual abuse investigations involving juvenile victims per Standard 115.334. All investigators

have received certifications for completed training from the National Institute of Corrections. Investigators interviewed demonstrated their understanding of interviewing youth, evidence collection in confinement settings, and criteria needed to substantiate a case.

(c): TJJD policy requires that investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence. They will include any available electronic monitoring data, interview appropriate persons, and review prior complaints involving the alleged perpetrator. Interviews with investigative staff demonstrate knowledge of conducting investigations of this type. The AID and OIG investigative reports include preliminary findings and determinations of resulting full investigations, evidence collected such as interviews with staff members and youth, video and document review, and outcome decisions. The State of Texas Retention Schedule for TJJD investigative files states that AID files are retained for five years after the case is closed. OIG criminal investigative files are retained for 20 – 50 years depending on the type of case. The auditor observed the area in which AID records are stored near the Director of AID's office in the agency's central office. The director confirmed that the AID files were retained for at least five years.

(d): TJJD policy requires that investigations will not be terminated because the source of the allegation recants the allegation. The investigators supported compliance with this standard stating that an investigation would not end due to an allegation being recanted.

(e): TJJD policy requires that when the evidence supports criminal prosecution, compelled interviews may be used, but only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The AID and OIG investigators stated OIG would conduct compelled interviews only if there was sufficient evidence to do so. The AID investigative report did not indicate compelled interviews took place. Criminal reports were not reviewed, as OIG is considered an outside investigative entity.

(f): TJJD policy requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a youth or staff. The policy states they do not require youth who allege sexual abuse to submit to a polygraph or other truth-telling device as a condition for proceeding with the investigation. Interviews with two investigators confirmed understanding of and compliance with this practice. The youth who reported a sexual abuse said that he was not required to take a polygraph.

(g): TJJD policy requires that administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, policy requires investigators to document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. The AID investigative report indicates evidence including video and witness statements was analyzed when considering whether the actions of the staff member contributed to the abuse.

(h): TJJD policy requires criminal investigations conducted by OIG to be documented in a written report that includes the evidence and attach copies of documentary evidence where possible. Criminal reports were not reviewed, as OIG is considered an outside investigative entity.

(i): TJJD policy requires that substantiated allegations of conduct that appear to be criminal are referred for prosecution. The OIG PAQ states that there have been three substantiated allegations of conduct which appeared to be criminal and, therefore, were referred for prosecution since the last PREA audit. This report was not reviewed, as OIG is considered an outside investigative entity.

(j): TJJD policy requires the agency to retain all written administrative investigative reports for as long as the alleged abuser is incarcerated or employed by the agency, which aligns with The State of Texas Retention Schedule for TJJD administrative investigative files. The Director of AID confirmed that administrative investigation reports were retained as required by the standard. Additionally, the electronic filing system used by investigators starting in 2018 and the filing area for multiple years of investigation files were observed.

(k): TJJD does not terminate investigations solely on the basis that the alleged abuser or victim is no longer with the agency. The AID and OIG investigators said the investigation would continue regardless if the alleged abuser or victim is no longer employed or placed at Giddings.

(l): According to TJJD policy, OIG follows the above provisions.

(m): TJJD policy requires that staff members cooperate with outside agencies that conduct investigations and remain informed about the progress of the investigations. During interviews, the Superintendent, Compliance Manager, and PREA Coordinator stated that overall, the investigators keep them informed. An OIG investigator stated that during investigations, not all information is relayed to facility staff members in order to maintain the integrity of the investigations.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency conducts thorough and prompt investigations; b) investigators must have specialized training; c) investigators shall gather evidence and shall review prior complaints involving the suspected perpetrator; d) the investigation continues if the complainant recants the allegation; e) the agency conducts compelled interviews only after consulting with prosecutors; f) the credibility of the alleged victim shall be assessed on a case-by-case basis, and no polygraphs or truth-telling devices are used as a condition of continuing the investigation; g) administrative investigations shall include the consideration of staff actions and shall be documented in written reports; h) criminal investigations shall be documented in written reports; i) substantiated allegations that appear criminal shall be referred for prosecution; j) the agency maintains all written reports as long as the alleged abuser is incarcerated or employed by the agency plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention; k) the departure of the alleged abuser or victim from the facility or from employment shall not provide a basis for terminating an investigation; and m) the facility cooperates with outside investigators. Provision (l) is not required to be audited.

The auditor determined that the TJJD policy addresses each of these provisions, which supports compliance with provisions (a) – (m).

The auditor determined compliance with provision (a) after reviewing three administrative investigative reports following allegations of sexual abuse. All appeared to have been thoroughly and objectively conducted within approximately 30 days, as all contained the dates of the initiation and conclusion of the investigation and the comprehensive notes, evidence collected, and actions taken. Compliance with provision (b) was based on certificates of completion of the specialized training the investigators received. The investigative reports include details about the evidence reviewed including youth and staff statements and video footage, which support compliance with provision (c). Compliance with provision (d) was determined, as no youth recanted his allegation, and no administrative investigation resulted in a referral for prosecution. Compliance with provision (f) was based on the investigators' responses during interviews. The reports contained details regarding the consideration of staff actions as contributing factors, which support compliance with provision (g). Compliance with provisions (a) – (m) was based on interview responses, which revealed an understanding of the requirements of each provision. Since policy, interview responses, and investigative reports demonstrated compliance with each provision, the auditor determined Giddings meets the requirements of this Standard.

Corrective Action: None

Standard 115.372: Evidentiary Standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a Standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Investigative reports

Interviews:

1. Administrative investigator

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that the standard of proof used by the agency in administrative investigations is a preponderance of the evidence. The interview with the facility investigator confirmed his knowledge of the required standard of proof and that his practice was to use “preponderance of the evidence” in investigations. The three investigative reports contained an explanation of this standard of proof and the justification of the finding based on this standard.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency standard to substantiate a case is a preponderance of the evidence. Policy addresses this standard; the investigator communicated an understanding of this provision; the investigative reports indicate the standard of proof is a preponderance of the evidence; therefore, the auditor determined Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.373: Reporting to residents**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.373 (a)**

- Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?
☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency request the relevant information from the

investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No
☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?
☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?
☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications?
☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Administrative investigative reports
4. Youth notifications

Interviews:

1. Superintendent
2. Investigative staff
3. Youth who reported a sexual abuse

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that until the youth is discharged from TJJD, the facility will inform the youth whether the allegation is substantiated, unsubstantiated, or unfounded. Interviews with investigative staff corroborate this is the practice. The notifications document provided by the

Compliance Manager contained information about all facility investigations including those related to sexual abuse/harassment, the date the case was assigned, the entity to which it was assigned, closing date, allegation, date the notification was sent, disposition, and other information.

The OIG reported on the PAQ that in the past 12 months, there were three notifications as indicated in the table below. The notifications document and a follow-up email with the Compliance Manager confirmed this number. In their interviews, the OIG and AID investigators stated that they inform the facility when an investigation closes, and the facility was responsible for sending the notification. Facility staff members corroborated this practice.

	Facility	AID	OIG
115.322 (a)-2 Number of Allegations Received	Not answered	63	127
115.322 (a)-3 Number resulting in administrative investigations	Not answered	63	Not answered
115.322 (a)-4 Referred for criminal investigation	Not answered	Not answered	75
115.322 (a)-5 All criminal/administrative investigations were completed	Not answered	No	No
115.352 (d)-2 Number of grievances/complaints filed	0	63	Not answered
115.352 (d)-3 Number administrative investigations completed within 90 days	0	61	Not answered
115.352 (d)-4 Number administrative investigations requiring an extension	Not answered	1	Not answered
115.364 (a)-2 Number of allegations that a resident was sexually abused/assaulted	0	63	Not answered
115.371 (i)-2 Number of sustained allegations referred for prosecution	Not answered	Not answered	3
115.373 (a)-2 Number of criminal/administrative investigations completed by the agency	Not answered	62	65
115.373 (a)-3 Of the criminal/administrative investigations completed, the number of youth who were notified of the investigation results	Not answered	Not answered	Not answered
115.373 (e)-3 Number of notifications to youth pursuant to this standard	3	Not answered	Not answered

115.378 (a)-3 Number of administrative findings of youth-on-youth sexual abuse	5	Not answered	Not answered
115.378 (a)-4 Number of criminal findings of youth-on-youth sexual abuse	Not answered	Not answered	Not answered
115.386 (b)-2 Number of criminal/administrative investigations excluding unfounded	Not answered	13	27

(b): TJJD Policy outlines the requirements of the OIG and is discussed above in Standard 115.322. The OIG investigator stated that he informs the facility when an investigation is closed and has reached a disposition and that not all information is provided to maintain the integrity of the investigation. The Compliance Manager stated that she was provided information on the majority of the investigations, and the notifications document indicates this is as well.

(c): TJJD policy requires that youth are notified when 1) the staff member is no longer posted within the youth's unit, 2) the staff member is no longer employed at the facility, 3) when the staff member has been indicted, or 4) when the staff member has been convicted on a charge related to sexual abuse within the facility. There were two cases in which a staff member was confirmed to have violated a rule. These included maintaining an appropriate adult/youth relationship and complying with TJJD rules, policies, procedures, and guidelines. In each of these, copies of the notifications were provided to evidence that they were sent to parents, the youth involved, and to a DFPS case worker informing the worker of the case being open and the disposition once it was closed. The AID investigative staff member and the Superintendent said youth and parent notification is the responsibility of the Superintendent. The youth who reported a sexual abuse said that he was informed that the AID case was closed and that the staff member no longer worked at the facility.

(d): TJJD policy requires that following a youth's allegation that he or she was sexually abused by another youth, TJJD informs the youth when 1) the abuser has been indicted, or 2) the abuser has been convicted on a charge related to sexual abuse. No cases pursuant to this provision were provided to review; however, letters notifying parents or staff members of the opening and closing of administrative investigations of alleged mistreatment were provided and described above.

(e): TJJD policy does not require documentation on all such notifications or attempted notifications under this standard. Since the OIG is an outside investigative entity, this standard was not audited.

(f): TJJD policy requires that the notification obligations of this standard apply until the youth is discharged from TJJD.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) following an investigation, the agency shall inform the resident of the outcome; c) the agency informs the resident when the staff member is no longer posted in the resident's unit, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility; d) following a resident's allegation that he or she has been sexually abused by another resident, the agency informs the alleged victim whenever the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility; and e) notifications are documented. Provision (e) was not audited, as the OIG is considered an outside investigating entity.

The auditor determined TJJD policy addresses each audited provision, which supports compliance with each applicable provision. The investigative reports and resulting notifications, the notification document, and interviews with the Compliance Manager and investigators demonstrated compliance with all audited provisions. Since the facility demonstrated compliance with each provision, the auditor determined Giddings meets the requirements of this standard.

Corrective Action: None

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history,

and the sanctions imposed for comparable offenses by other staff with similar histories?

☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (I)
3. Administrative investigative reports
4. Staff discipline reports
5. Staff disciplinary sanctions
6. Employee handbook

Interviews: No interviews protocols are directly related to this standard.

Observations: Shower areas and live video

(a): TJJD policy requires that staff members who violate the agency's sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination.

(b): TJJD policy requires that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. This information is also included in the employee handbook. In the past 12 months, the facility reported that four staff members have violated the TJJD policy on sexual abuse or sexual harassment, and three were terminated or resigned prior to termination. The employee discipline report showed three staff members' incidents, event comments describing the violation, and the discipline imposed including termination and being placed on probation.

(c): TJJD policy requires that disciplinary sanctions will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The facility reported one instance of a staff member being disciplined, short of termination, for violating the agency's sexual abuse or sexual harassment policy. The employee discipline report indicated that one staff member was placed on probation for 12 months for recklessly viewing youth from the control center during shower routine. During the facility inspection, the shower areas in all dorms and live video feed from the shower areas in two dorms provided sufficient privacy but would allow viewing of approximately below the youth's knees and the shoulder area.

(d): TJJD policy requires reporting the following actions to licensing bodies 1) terminations of employment for violations of TJJD sexual abuse or sexual harassment policies, and 2) resignations by staff members who would have been terminated if they had not resigned. The PAQ indicated that no staff members were reported to law enforcement or licensing boards for violating the agency's sexual abuse or sexual harassment policy.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) staff shall be subject to disciplinary sanctions up to and including termination for violations of PREA policy, b) termination is the presumptive sanction for sexual abuse, c) sanctions are commensurate with the nature of the violation, and d) terminations for PREA violations shall be reported to law enforcement agencies.

Policy addresses all provisions, which evidences compliance with this standard. The employee discipline reports provided evidence of compliance with provisions (b) and (c), and provision (d) was found compliant, as there were no reports made to law enforcement. Since the facility demonstrated compliance with all provisions, the auditor concluded that Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☐ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (I)
3. Memorandum from Superintendent

Interviews:

1. Superintendent

(a): TJJD policy requires that if a contractor or volunteer engages in sexual abuse, TJJD prohibits the contractor or volunteer from having contact with youth and shall report the finding of abuse to relevant licensing bodies. In the past 12 months, the facility PAQ indicated that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of youth. A memo from the Superintendent states that Giddings has had no contractor or volunteer services postponed or terminated due to violations of PREA-related allegations or investigations in the past 12 months.

(b): TJJD policy requires that if a volunteer or contractor violates sexual abuse or sexual harassment policy, but does not actually engage in sexual abuse, TJJD will take appropriate remedial measures and considers whether to prohibit further contact. The facility reported no cases of a volunteer or contractor who was disciplined for policy violation. During her interview, the Superintendent stated that if a contractor or volunteer violated agency PREA policy, the he or she would be restricted from campus pending administrative action, the incident reported to the IRC, and an investigation assigned to OIG or AID.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) contractors or volunteers who violate PREA policy shall be prohibited from contact with residents and reported to law enforcement agencies if the activity was criminal and b) the facility shall take appropriate remedial measures in the case of any other violation of agency sexual abuse or harassment policies by a contractor or volunteer.

Since the facility reported no instances of volunteer or contractor PREA violations, the auditor determined compliance based on policy review and interview responses. TJJD policy addresses both provisions. The Superintendent's responses provided additional evidence of compliance, as she communicated knowledge of actions that would be taken following a PREA violation by a contractor or volunteer. Since compliance was demonstrated with both provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (I)
3. GAP 380.9555
4. GAP 380.9503

Interviews:

1. Superintendent
2. Medical and mental health staff

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that a youth may be subject to disciplinary sanctions only after a substantiated finding in an administrative investigation or a criminal finding that a youth participated in the sexual abuse of another youth or staff member. The facility reported that there have been five administrative findings and no criminal findings of youth-on-youth sexual abuse that occurred in the facility in the past 12 months. The youth handbook includes descriptions of the discipline process including major and minor rule violations, consequences, and the right to due process and appeals.

(b): TJJD policy requires that disciplinary sanctions must be commensurate with the nature and circumstances of the abuse committed, the youth's disciplinary history, and the sanctions imposed for comparable offenses by other youth with similar histories. Discipline is determined through a Level II due process hearing held in accordance with GAP 380.9555. The Superintendent said sanctions could include placement in the Redirect Program (a more restrictive program within Giddings), loss of privileges, or county jail. The Compliance Manager also demonstrated knowledge of the disciplinary process. The facility reported that in the past 12 months, there have been no youth placed in isolation as a disciplinary sanction for youth-on-youth sexual abuse. The hearing manager's report of level II hearings for the five youth who were found to have committed PREA-related rule violations were reviewed. The reports included an incident pointer, the allegation, evidence considered, finding, and disposition, all of which were stage demotion, and whether the youth appealed the decision. Although none of the five youth who received sanctions related to this standard were placed in the security unit/isolation, other youth who have been placed in the unit for rule violations unrelated to PREA stated that they received daily access to education, special education services, large muscle exercise, and visits from medical and mental health care staff.

(c): TJJD policy requires that the disciplinary process consider whether a youth's mental disability or mental illness contributed to his or her behavior. The interview with the Superintendent and medical and mental health care staff indicated this is the practice when determining youth sanctions.

(d): TJJD policy requires that the facility offer counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. TJJD may require participation as a condition of access to behavior-based incentives, but not as a condition to access general programming or education. Medical and mental health care staff members said counseling and therapy is offered to youth offenders and victims.

(e): TJJD policy requires that a youth may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact. This is preceded by a criminal investigation by the OIG.

(f): TJJD policy requires that a youth may not be disciplined if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

(g): TJJD policy prohibits all sexual activity between youth and may discipline a youth in accordance with GAP 380.9503 for engaging in sexual activity that meets the definition of abuse. Regardless of the conduct, all sexual misbehaviors are included in the agency data collection.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this Standard and the PREA Audit Tool, which require that: a) residents may be subject to sanction only pursuant to a formal disciplinary process; b) sanctions shall be commensurate with the circumstances of the abuse committed, and the facility must provide specific services to residents who receive sanctions resulting in isolation; c) the disciplinary process shall consider a resident's mental disability when determining sanctions; d) if the facility offers therapy, counseling, and other interventions, the facility shall consider whether to offer the services to the offender, and the agency may require participation in such interventions as a conditions of access to rewards-based incentives but not as a condition to access to general programming; e) the agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did no consent; f) reports made in good faith shall not constitute false reporting; and g) the agency may prohibit all sexual activity between residents, may discipline resident s for such activity, and may not deem the activity sexual abuse if it determines that the activity is not coerced.

The auditor determined that TJJD policy addresses each provision, which demonstrates compliance with all provisions. Staff members' interview responses confirmed their knowledge of the disciplinary and sanction process, and the hearing manager's reports indicated youth received sanctions commensurate with the rule violations, which demonstrates compliance with all provisions. Youth who have been placed in isolation stated they received access to campus services and received due process through a level II hearing. Since the facility demonstrated compliance with all provisions, the auditor determined Giddings meets the requirements of this standard.

Corrective Action: None

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. Intake screenings
4. Email thread regarding a questioning youth
5. Psychological evaluations

Interviews:

1. Medical and mental health care staff
2. Youth who reported prior sexual abuse during screening

Observations:

1. Area where youth files are stored

(a): TJJD policy requires that regardless of the intake screening results, the facility shall offer all youth, including youth offenders, a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. One psychological evaluation was reviewed on site, and two reviewed following the audit. Psychological assessments, treatment notes, and resulting mental health services such as trauma counseling, mental health treatment, and sexual behavior treatment showed that these services occurred within 14 days for those youth identified as needing these services. Two youth identified as having reported prior victimization were interviewed. One denied reporting, and the other said that once he reported the victimization, a mental health professional spoke with him in "less than a week."

(b): TJJD policy requires that any information obtained related to sexual victimization or abusiveness that occurred in an institutional setting must be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions including housing, bed, work, education and program assignments, or the facility in which they are placed. During interviews, the staff member responsible for the screening stated that follow-up services were provided immediately. Secondary materials are discussed in the provision above.

(c): Youth files are stored in the intake area in a secure location, which was observed during the facility inspection. Limited staff members have access to these files. Medical information is

stored in the Electronic Medical Records system through University of Texas Medical Branch, which also has limited access and is password protected.

(d): TJJD policy requires that staff members must obtain informed consent from youth age 18 or over before reporting information about prior sexual victimization that did not occur in an institutional setting. Interviews with mental health staff indicate that informed consent is obtained.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) if the intake screening indicates the resident has experienced prior sexual victimization, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; b) if the screening indicates the resident has previously perpetrated sexual abuse, the resident is offered a follow-up meeting with a medical or mental health care practitioner within 14 days of intake; c) any information related to sexual abuse or victimization shall be strictly controlled; and d) medical and mental health practitioners shall obtain informed consent before reporting information about prior victimization that did not occur in an institution, unless the resident is under the age of 18.

TJJD policy addresses each provision, which supports compliance with provisions (a) – (d). Compliance with provisions (a) and (b) was demonstrated during a review of psychological assessments and subsequent actions taken based on the screening information. The youth who said he received mental health services also demonstrated compliance with these provisions. Compliance with provision (c) was demonstrated during interviews, during which staff members explained the limited access to resident files containing sensitive information. Additional compliance was evidenced during the facility inspection when the auditor noted the area in which the files were stored. The auditor determined additional compliance with provision (d) during an interview with the Director of Nursing who communicated an understanding of informed consent. Since the facility demonstrated compliance with all provisions, the auditor determined that Giddings meets the requirements of this standard

Corrective Action: None

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are

determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted Standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. INS.71.01
4. Medical mental health records
5. Coordinated response plan

Interviews:

1. Medical and mental health care staff
2. Emergency room supervisor at a local medical center
3. Youth who reported a sexual abuse
4. Staff who conduct risk assessments

Observations:

1. Medical and mental health care service areas

(a): TJJD policy requires that youth victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners per their professional judgment. During interviews, the Giddings Director of Nursing stated that youth victims receive access to these services and that OIG determines if the youth will be transported to a hospital for a SAFE/SANE. During an informal interview with an OIG investigator, he stated the nature and scope of the services would be determined in collaboration with facility nursing staff. According to the coordinated response plan and INS, infirmery staff assesses the youth for injuries associated with the alleged sexual abuse, but OIG determines whether the youth will be transported to an off-site clinic for examination and treatment. Once the youth arrives to the off-site hospital, the SAFE/SANE nurse would determine further medical services.

The youth who reported a sexual abuse stated that he initially denied having a relationship with a JCO and was not provided access to these services. He said he would like to be screened for sexually transmitted diseases (STDs). During the exit meeting, medical and mental health services were requested on the youth's behalf.

(b): TJJD policy requires that if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse, staff first responders must take preliminary steps to protect the victim pursuant to Standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Interviews with staff demonstrated their knowledge of first responder protocols and procedures for cases of sexual abuse. The coordinated response plan includes the notification of medical and mental health care staff as a first responder duty.

(c): TJJD policy requires that the facility offers youth victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection

prophylaxis, in accordance with professionally accepted standards of care, and where medically appropriate. During interviews, the Director of Nursing said that the infirmary did not test for STDs, and if a youth was sexually abused, the testing would occur during the forensic exam. The interview with the emergency room supervisor at the local medical center confirmed that this would occur during the exam.

(d): TJJD policy requires that the facility shall offer these treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews corroborated that victims are not charged for these treatment services.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) resident victims of sexual abuse shall receive access to emergency medical treatment and crisis interventions as determined by medical and mental health practitioners; b) if no qualified staff members are on duty at the time of report of recent abuse, the first responder shall take steps pursuant to Standard 115.362 to protect the resident; c) resident victims of sexual abuse while incarcerated shall be offered information and access to emergency contraception and sexually transmitted infection prophylaxis in accordance with professionally accepted Standards of care; and d) treatment shall be provided at no cost to the resident.

The auditor determined that TJJD policy addresses each element of this standard, which demonstrates compliance with provisions (a) – (d). Policy aligns with provision (a), and the coordinated response and INS contain information about the decision-making process regarding emergency medical treatment for victims of sexual abuse.

The services described in this standard were not utilized during the audit period; however, youth files, medical records, and the investigative summaries provided sufficient evidence that medical and mental health care services are provided to all youth at no charge. The dedicated medical and mental health areas observed during the facility inspection indicate these areas are used to provide medical and mental health care, which supports compliance with provision (c). Additional evidence supporting compliance with provisions (b), (c), and (d) was based on interview responses. Staff members articulated their knowledge of the general medical and mental health care services all youth receive and emergency services that would be provided if needed. Youth also confirmed that they receive general medical and mental health care services at no cost.

Corrective Action: None

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. GAP 380.9195
4. INS 71.01 (2)
5. Medical records
6. On-going treatment
7. Investigative reports
8. Youth files

Interviews:

1. Medical and mental health care staff
2. Youth who reported a sexual abuse

3. Staff who conduct risk assessments

Observations:

1. Medical and mental health care service areas

(a): TJJD offers medical and mental health evaluations and, as appropriate, treatment to all youth who are victims of sexual abuse in any facility. Interviews with medical and mental health staff indicated all youth undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed. The auditor reviewed psychological assessments to ensure documentation of initial and on-going medical and mental health care services.

(b): TJJD policy requires that the evaluation and treatment of victims include follow-up services, treatment plans, and referrals for continued care following a youth's transfer to other facilities or release from custody. Medical and mental health care staff members said counseling and therapy was offered to youth offenders and victims. The action taken following two SARBs in the last 12 months provided evidence that youth received trauma assessments following alleged sexual abuse, harassment, or misconduct. The youth who reported sexual contact with a staff member said that no one spoke with him or offered medical or mental health services. He said he initially denied any sexual misconduct and that he consented to the relationship and sexual acts. Services were requested on his behalf during the exit meeting and an investigation is underway. Details are discussed above in Standard 115.321 and on pages 12-13.

(c): During interviews, medical and mental health care staff reported the level of care received at Giddings through on-site psychology and the University of Texas Medical Branch is consistent with or exceed the community level of care.

(d): TJJD policy requires that pregnancy tests are offered to youth victims of sexually abusive vaginal penetration that occurs while they are incarcerated at a TJJD facility. Giddings is an all-male facility; therefore, no interviews pursuant to this provision were conducted.

(e): TJJD policy requires that if pregnancy results from a sexual assault, the youth is provided timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Additional services provided to youth are included in GAP 380.9195. Giddings is an all-male facility; therefore, no interviews pursuant to this provision were conducted.

(f): TJJD policy requires TJJD to offer tests for sexually transmitted infections, as medically appropriate, to youth victims of sexual abuse while incarcerated. The youth whose investigation is underway stated that he was not offered these tests because he denied sexual misconduct but that he would now like to be tested. The auditor requested the test on the youth's behalf during the exit meeting.

(g): TJJD policy requires that all treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The auditor requested these services for a youth who reported sexual contact with a JCO during interviews.

(h): TJJD policy requires that TJJD attempts to conduct a mental health evaluation of all known youth-on-youth abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health care staff. Medical and mental health staff members reported that all youth receive a mental health evaluation during intake and periodically throughout their stay.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the facility shall offer medical and mental health evaluations to all residents who have been victimized in a juvenile facility; b) the evaluation and treatment shall include follow-up services, treatment plans, and referrals for continued care if necessary; c) the facility shall provide services consistent with the community level of care; d) resident victims of vaginal penetration shall be offered pregnancy tests; e) if pregnancy results, the victim shall receive access to lawful pregnancy-related medical services; f) resident victims while incarcerated shall be offered tests for sexually transmitted infections; g) treatment shall be provided at no cost to the resident; and h) the facility shall attempt to evaluate all known resident-on-resident abusers within 60 days of learning of such history and offer treatment when deemed appropriate by mental health care staff.

The auditor determined that TJJD policy addresses all elements, which supports compliance with provisions (a) – (h). During the facility inspection, the auditor team conducted a walkthrough of the medical area. Several youth were observed receiving services in the infirmary, which appeared to be utilized by the facility, thus supporting compliance with provision (a). Although the youth who reported a sexual abuse had not received medical or mental health services, the auditor determined compliance with provisions (b) and (c) following a review of electronic youth medical and mental health documentation, which contained psychological and psychiatric evaluations and progress notes, thus indicating youth receive ongoing mental and medical health care. During interviews, youth confirmed they receive these services, which provided additional support of compliance with these provisions. Giddings is an all-male facility; therefore, no youth received the services pursuant to provisions (e) and (f). The auditor determined compliance with these provisions based on policy review. Compliance with provision (g) was also based on interviews, during which staff and youth confirmed medical and mental health care services are provided at no cost. Since the facility exceeds the 60-day requirement of providing additional services, and all youth receive ongoing treatment, the auditor determined compliance with provision (h). Since the facility demonstrated compliance with all provisions, the auditor determined Giddings meets the requirements of this standard.

Corrective Action: None

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (n)
3. SARB forms

Interviews:

1. Facility Superintendent
2. Compliance Coordinator
3. Incident review team member

Observations: No observations relative to this standard were required.

(a): TJJD policy requires Giddings to conduct a SARB at the conclusion of every sexual abuse investigation unless the allegation is determined to be unfounded. The team includes managers, supervisors, investigators, and medical and mental health practitioners. The team considers 1) whether the allegation or investigation indicates a need to change policy or practice, 2) whether the incident was motivated by race, ethnicity, gender identity, status or perceived status as LGBT, gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility motivated the incident, 3) physical barriers that may enable abuse, 4) staffing levels, and 5) whether monitoring technology should be enhanced. Policy requires that following the SARB, Giddings implement the review team's recommendations or reasons for not doing so.

The OIG and AID reported that in the past 12 months, there have been 13 administrative investigations and 27 criminal investigations. Three full AID investigative reports and their corresponding SARB were reviewed. The OIG is considered an outside investigative entity; therefore, the auditor did not review criminal investigative reports.

(b): TJJD policy does not require the review to occur within 30 days of the conclusion of the investigation. Of the 22 SARBs reviewed, three investigations resulted in corresponding SARBs that were held within 60 days, and two were held several days late. The remaining SARBs were held within 30 days. The facility reported that a SARB convenes within 30 days of receipt of the final case closure notification from OIG and AID. The Compliance Manager stated that the SARBs not occurring within 30 days was due to the facility not being notified within 30 days of the closure of the case. Two SARB forms indicated the facility was not notified within 30 days.

(c): TJJD policy requires that managers, supervisors, investigators, and medical or mental health practitioners participate in the review. The SARB reports reviewed did not list medical or mental health practitioners as participants in the review as required by TJJD policy and this provision, but the Compliance Manager confirmed that medical and mental health care staff are members of the review team and attend when a youth has received these services.

(d): SARB forms included discussion topics, which addressed each of the elements for this provision. Actions taken as a result of reviews included youth trauma counseling, restricting staff members from the dorm in which the incident occurred, placing youth on safety plans, assigning retaliation monitoring, and terminating staff. The Superintendent, Compliance Manager, and a member of the incident review team demonstrated knowledge of the items considered and provided examples of the resulting actions.

(e): TJJD policy requires that the facility implement the SARB team's recommendations or document the reasons for not doing so. Action plans that were implemented included housing changes, video review, and staff reassignments. Interviews with the Compliance Manager and Superintendent corroborated the practice of implementing the action plans following a SARB. One SARB following a staff member's report and resulting AID investigation indicated the facility did not complete all of the review team's recommendations. The SARB committee

identified eight actions, five of which were completed. Actions with no completion date included: review room lighting, staff verbal reminders, and video review of archival footage.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this Standard and the PREA Audit Tool, which require that: a) the facility shall conduct an incident review at the conclusion of every sexual abuse investigation; b) the review shall be conducted within 30 days of the conclusion; c) the review team shall include upper-level management and input from line supervisors, investigators, and medical and mental health care staff; d) the review team shall consider policy or practice change, potential motivations of the incident, the area where the incidence allegedly occurred, and monitoring technology, and prepare a report of findings; and e) the facility shall implement recommendations for improvement or document the reasons for not doing so.

The auditor determined TJJD policy addresses all provisions except provision (b). To determine compliance with provision (a), the auditor reviewed SARBs uploaded for every month during which reviews were held. The SARB form lists members who were present or absent. No form listed any members absent; those who were present for all SARBs reviewed included the Superintendent, Compliance Manager, other facility and central office supervisors, and OIG and AID investigators. SARBs were held for all PREA-related cases including those that were closed as unfounded, which exceed the requirement of provision (a). Since policy does not address provision (b), the auditor considered whether the SARBs occurred within 30 days as required by this provision and determined the facility demonstrated sufficient compliance with the 30-day timeline. A recommendation was provided to address the late SARBs. Although medical and mental health care did not attend the review meetings, the Compliance Manager stated that their input is considered when youth receive these services, which demonstrated compliance with provision (c). The items pursuant to provision (d) were included in the review and notes addressing the items support compliance with this provision. The team's recommendations were listed on the SARB form and included the dates the actions were completed for all but several actions, which the auditor determined was sufficient evidence of compliance with provision (e). Since compliance demonstrated for all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

Recommendations:

1. Since not all SARBs were held within 30 days of the closure of an investigation, include in the SARB documentation the reason and/or justification that the SARB was late.

2. One SARB did not include completion dates for all actions recommended by the SARB team. As required by provision (e), Giddings should document the reason for any incomplete recommendation or action.

Corrective Actions Taken in Response to the Auditor's Recommendation:

The facility Compliance Manager provided two SARBS conducted during the corrective action period. Both included evidence demonstrating that the SARB was held within 30 days of the closure of the investigation, as well as the allegation, investigation results, findings, notices provided to the parent/guardian, and actions taken.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?
☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o)
3. Copy of definitions
4. Data collection Instrument
5. Documentation of approval by the TJJD Executive Director
6. TJJD website

Interviews: No interviews relative to this standard were required.

Observations: No observations relative to this standard were required.

(a): TJJD policy requires that TJJD collect data for every allegation of sexual abuse at TJJD-operated facilities using a standardized instrument and set of definitions. TJJD also maintains,

reviews, and collects data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews. TJJD develops its data collection instrument to include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U.S. Department of Justice (DOJ). The collection system pulls data from TJJD's database with youth records to include additional information such as youths' age and gender.

(b): TJJD policy requires that TJJD aggregate the data at least once each year. The auditor reviewed a screen shot of the PREA Data Collection System that included incident type and allegation status of ongoing investigations cases. The auditor reviewed the TJJD website and noted that the annual reports were available for two consecutive annual surveys of sexual victimization, which contain the most current data available.

(d): TJJD policy requires that TJJD maintain, review, and collect data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews.

(e): TJJD policy requires that TJJD obtain incident-based and aggregate data from each residential facility operating under a contract with TJJD. The auditor reviewed a screen shot from 2013 of the PREA Data Collection System to ensure the data is aggregated by each facility. The auditor reviewed the most recent annual report to confirm that sexual abuse data was collected at state-operated and contracted facilities.

(f): TJJD policy does not require the agency to provide all such data from the previous calendar year to the DOJ no later than June 30, but a review of TJJD's website indicated the Survey of Sexual Victimization was completed for the years 2015 and 2016, which indicated this is the regular practice, and the data is provided annually.

Corrective Action: None

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?
☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and

response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?
☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (p)
3. Memorandum of Data Reviews/Corrective Actions
4. Data collection instrument
5. Annual PREA compliance reports
6. TJJD website

Interviews:

1. Superintendent
2. Executive Director
3. Compliance Coordinator
4. Compliance Manager

Observations: Staff members assigned to review live video and assigned to dorm control rooms

(a): TJJD policy requires that TJJD review aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole. The TJJD Executive Director indicated her knowledge of the data review. The Compliance Coordinator said each facility prepares an annual corrective action plan based on the allegations explaining what actions they will take to further prevent, detect, and respond to allegations of sexual abuse and harassment. A memo to the Director of Secure State Facilities and Compliance Coordinator from the Superintendent of Giddings stated that in response to confirmed cases of sexual misconduct, measures taken to ensure the safety of youth included:

- Reviewing camera blind spots
- Conducting DVR reviews
- Conducting unannounced rounds twice per month
- Announcing opposite gender staff members' presence in dorms
- Performing routines and searches by appropriate-gender staff
- Maintaining proper ratios
- Implementing safety and boundary plans for high-risk youth
- Updating safe housing following due process hearings
- Reviewing safe housing rosters
- Staffing all dorm control centers
- Assigning a staff member to view live video across the campus

(b): TJJD policy states that, "TJJD reviews aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole. The report will be posted on the agency's website." The auditor reviewed the 2016 Annual

Report to ensure the review included a comparison of the previous year's sexual abuse data. The report compares the years 2014, 2015 and 2016. The Annual Report includes aggregated data for TJJD facilities and contract facilities, agency-wide current and future plans, corrective actions, and proactive steps taken to eliminate sexual abuse and harassment. The Giddings plan is discussed above in subsection (a).

(c): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. Although policy does not require the Executive Director to approve the report, documentation of this approval was provided. The TJJD Director said that she would be approving the upcoming report.

(d): A review of the posted data indicates TJJD takes appropriate measures to redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. The Compliance Coordinator reported that all personal information on a perpetrator, victim, or witness is redacted from the annual report prior to submission of the report.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall review and assess the data collected pursuant to Standard 115.387 and prepare a report of findings; b) the report shall include a comparison of the current year's data and corrective actions to prior years and provide the agency's progress in addressing sexual abuse; c) the report shall be approved by the agency head and be made available to the public; and d) the agency may redact material if it presents a clear and specific threat to the safety and security of the facility.

The auditor determined TJJD policy addresses provisions (a), (b), and (d). Additional compliance with provision (a) was based on a review of the corrective actions detailed in the report. The auditor reviewed Giddings' preventative measures and confirmed through the interview with the Superintendent that the facility has implemented each measure. Two of the actions were observed during the facility inspection: staff members reviewing live video and staff members posted in each dorm control room, which provided additional evidence of compliance with provision (b). The auditor based compliance with provision (c) on interviews, during which the Executive Director stated she would approve the report before it was posted on the website. During interviews, the Compliance Coordinator stated that all personal information is redacted from the report prior to its publication. The auditor's review of the reports confirmed that no personal identifiers were included, which supports compliance with provision (d). Since the facility demonstrated compliance with each provision, the auditor determined that Giddings meets the requirements of this standard.

Corrective Action: None

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o), (p)
3. TJJD website

Interviews:

1. Superintendent
2. PREA Compliance Coordinator

Observations: No observations relative to this Standard were required.

(a): TJJD policy requires that all sexual abuse data is securely retained. The Compliance Coordinator confirmed compliance and stated the data is password protected. The data is derived from the OIG and AID databases, and access to these are strictly limited.

(b): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. The auditor confirmed the data is included on the TJJD website.

(c): A review of the published data revealed that TJJD removes all personal identifiers prior to making aggregated sexual abuse data publicly available.

(d): PREA Standard 115.389 requires TJJD to maintain sexual abuse data for at least 10 years after the date of its initial collection, unless Federal, State, or local law requires otherwise. Historical data is available on the website beginning in 2012, which supports compliance with this subsection.

Summary of Findings:

The auditor assessed TJJD policy against the elements of this standard and the PREA Audit Tool, which require that: a) the agency shall ensure the data collected pursuant to Standard 115.387 are securely retained; b) the agency shall make the data available to the public; c) the agency removes personal identifiers from the public data; and d) the agency maintains the data for 10 years.

The auditor determined TJJD policy addresses provisions (b) and (c). The auditor visited the agency website to confirm the aggregated data with personal identifiers removed is readily available to the public. Compliance with provision (a) was based on the interview with the Compliance Coordinator who confirmed the data is securely stored on state servers. The agency is required to maintain sexual abuse data for at least 10 years, which demonstrates compliance

with provision (d). Since Giddings demonstrated compliance with all provisions, the auditor determined the facility meets the requirements of this standard.

Corrective Action: None

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this Standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this Standard.*) ☒ Yes ☐ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?
☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (q)
3. TJJD website
4. Photographs of audit notice posting
5. Overall documentation uploaded to a secure drive

Interviews: No interviews specific to this standard were conducted

Observations:

1. All areas within the facility

(a): TJJD policy requires that TJJD conduct audits pursuant to the Code of Federal Regulations relating to the PREA (28 CFR 115.401 – 115.405). The TJJD website contains the final PREA

reports for state secure, state halfway houses, contract facilities, and county facilities. Audits were conducted for all TJJD-operated facilities during the prior three-year audit period. There are no facilities operated by a private organization on behalf of the agency.

(b): This is the second year of the current audit cycle. During the first year of the cycle, PREA audits were conducted for four of the 13 TJJD-operated facilities.

(h): During the on-site portion of the audit, the auditor conducted a facility inspection and observed all areas inside the secure fence.

(i): The auditor received documentation relevant to each PREA standard prior to the on-site audit. Additional documents were requested and sent via email or uploaded to the secure drive. During the on-site portion, personnel and youth files were reviewed, and additional documents were reviewed with the Compliance Manager and Human Resources Administrator.

(m): During the facility inspection, the auditor informally interviewed youth and staff in each area. Following the inspection and during the second day of the audit, formal interviews with staff members and youth were conducted in private areas in a dorm and the administration building.

(n): Prior to the on-site audit, notices were posted that included necessary contact information, thus enabling youth to send confidential information or correspondence to the auditor. The auditor did not receive such correspondence.

Summary of Findings:

The auditor assessed TJJD policy and practice against the elements of this standard, which require that: a) during the three-year period starting on August 21, 2013, and each three-year period thereafter, the agency shall ensure each facility is audited at least once; b) during each one-year period, the agency shall ensure that each facility type is audited; h) the auditor shall have access to and observe all areas of the facility; i) the auditor shall be permitted to request and receive relevant documents; m) the auditor shall be permitted to conduct private interviews with residents; and n) residents shall be permitted to send confidential correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Compliance with provision (a) was based on the auditor's review of the TJJD website, which contains links to PREA audit final reports that were conducted beginning in 2014, which evidenced that each facility was audited at least once during the three-year cycle. The auditor relied upon policy and the PREA-related activities included in the annual report to determine compliance with provision (b). Since the auditor team was provided access to all areas within the facility during the facility inspection, compliance with provision (h) was demonstrated. Since the auditor was granted access to and permitted to request and received relevant documents prior to, during, and after the on-site audit portions, compliance with provision (i) was demonstrated. The auditor team was provided private areas in which to conduct interviews with youth, and thus demonstrated compliance with provision (m). The audit notices that were posted throughout the

facility prior to the onsite audit enabled youth and staff to correspond with the auditor by including the auditor's contact information; thus compliance with provision (n) was demonstrated. Since the facility complied with each provision, the auditor determined TJJD meets the requirements of this standard.

Corrective Action: None

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of Standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the Standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the Standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. TJJD website
2. Final audit reports of TJJD facilities

Interviews: No observations relative to this standard were required.

Observations: No observations relative to this standard were required.

(f): The TJJD website contains prior final audit reports that were posted within 90 days of issuance by the auditor.

Summary of Findings:

The auditor assessed TJJD practice against the elements of this Standard, which require that: f) the agency shall ensure that the auditor's report is published on the agency website or otherwise made readily available to the public.

The auditor determined compliance with this provision by visiting the agency website and confirming previous audit reports are posted; thus the facility meets the requirements of this standard.

Corrective Action: None

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditor must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Nicole Prather

March 12, 2019

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.